# Summerset Care Limited - Summerset in the Bay

## Current Status: 15 September 2014

**The following summary has been accepted by the Ministry of Health as being an accurate reflection of the** **Surveillance Audit conducted against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) on the audit date(s) specified.**

## General overview

The service provides care for up to 58 residents. The 48 beds in the care centre provide either rest home or hospital level care (dual service). There are also 10 care apartments certified to provide rest home level of care. The facility is appropriately staffed across the 24 hour period. The service is managed by a non-clinical village manager who is supported by a nurse manager. There are job descriptions for both positions that include responsibilities and accountabilities. Summerset's operations manager, clinical educator and clinical, quality manager are available to support the team at Summerset in the Bay.

The service has addressed the four shortfalls identified in their previous certification audit around care plans, wound assessments, evaluation of care plans and medication administration documentation.

This audit has identified improvements required around meeting minutes, review of the hazard register, documentation of interventions, medication standing orders, self-medication assessments, enabler and restraint documentation.

## Audit Summary as at 15 September 2014

Standards have been assessed and summarised below:

### Key

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

### Consumer Rights as at 15 September 2014

|  |  |  |
| --- | --- | --- |
| 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. |

### Organisational Management as at 15 September 2014

|  |  |  |
| --- | --- | --- |
| 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. |

### Continuum of Service Delivery as at 15 September 2014

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of low risk. |

### Safe and Appropriate Environment as at 15 September 2014

|  |  |  |
| --- | --- | --- |
| 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. |

### Restraint Minimisation and Safe Practice as at 15 September 2014

|  |  |  |
| --- | --- | --- |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Some standards applicable to this service partially attained and of low risk. |

### Infection Prevention and Control as at 15 September 2014

|  |  |  |
| --- | --- | --- |
| 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. |

# HealthCERT Aged Residential Care Audit Report (version 4.2)

## **Introduction**

This report records the results of an audit against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) of an aged residential care service provider. The audit has been conducted by an auditing agency designated under 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).

It is important that auditors restrict their editing to the content controls in the document and do not delete any content controls or any text outside the content controls.

## **Audit Report**

|  |  |
| --- | --- |
| **Legal entity name:** | Summerset Care Limited |
| **Certificate name:** | Summerset Care Limited - Summerset in the Bay |

|  |  |
| --- | --- |
| **Designated Auditing Agency:** | Health and Disability Auditing New Zealand Limited |

|  |  |
| --- | --- |
| **Types of audit:** | Surveillance Audit |
| **Premises audited:** | Summerset in the Bay |
| **Services audited:** | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) |
| **Dates of audit:** | **Start date:** | 15 September 2014 | **End date:** | 15 September 2014 |

**Proposed changes to current services (if any):**

|  |  |
| --- | --- |
| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 50 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXXXXX | **Hours on site** |  | **Hours off site** |  |
| **Other Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXXXX |  |  | **Hours** | 1 |

## **Sample Totals**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 16 | Total audit hours off site | 11 | Total audit hours | 27 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed |  | Number of staff interviewed |  | Number of managers interviewed |  |
| Number of residents’ records reviewed |  | Number of staff records reviewed |  | Total number of managers (headcount) |  |
| Number of medication records reviewed |  | Total number of staff (headcount) |  | Number of relatives interviewed | 4 |
| Number of residents’ records reviewed using tracer methodology |  |  |  | Number of GPs interviewed | 1 |

## **Declaration**

I, XXXXXXXX, Director of Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Act.

I confirm that:

|  |  |  |
| --- | --- | --- |
| a) | I am a delegated authority of Health and Disability Auditing New Zealand Limited | Yes |
| b) | Health and Disability Auditing New Zealand Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise | Yes |
| c) | Health and Disability Auditing New Zealand Limited has developed the audit summary in this audit report in consultation with the provider | Yes |
| d) | this audit report has been approved by the lead auditor named above | Yes |
| e) | the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook | Yes |
| f) | if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider | Yes |
| g) | Health and Disability Auditing New Zealand Limited has provided all the information that is relevant to the audit | Yes |
| h) | Health and Disability Auditing New Zealand Limited has finished editing the document. | Yes |

Dated Monday, 20 October 2014

## **Executive Summary of Audit**

**General Overview**

The service provides care for up to 58 residents. The 48 beds in the care centre provide either rest home or hospital level care (dual service). There are also 10 care apartments certified to provide rest home level of care. On the day of audit there are 27 rest home residents (including three in the serviced apartments) and 23 hospital level of care residents. The facility is appropriately staffed across the 24 hour period. The service is managed by a non-clinical village manager who is supported by a nurse manager. There are job descriptions for both positions that include responsibilities and accountabilities. Summerset's operations manager, clinical educator and clinical, quality manager are available to support the team at Summerset in the Bay. The service has addressed the four shortfalls identified in their previous certification audit around care plans, wound assessments, evaluation of care plans and medication administration documentation.

This audit has identified improvements required around meeting minutes, review of the hazard register, documentation of interventions, medication standing orders, self-medication assessments, enabler and restraint documentation.

**Outcome 1.1: Consumer Rights**

Families are kept informed of changes in resident health. Complaints processes are implemented and complaints and concerns are managed and documented.

**Outcome 1.2: Organisational Management**

Summerset in the Bay is implementing a quality and risk management system that supports the provision of clinical care. An annual resident satisfaction survey is completed and there are regular resident meetings. Quality performance is reported to staff at meetings and includes discussion about incidents, infections and internal audit results. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care and support and external training is supported. The staffing policy aligns with contractual requirements and includes skill mixes. There are two improvements required around meeting minutes, and review of the hazard register.

**Outcome 1.3: Continuum of Service Delivery**

Assessments, care plans and evaluations are completed by the registered nurses. Risk assessment tools and monitoring forms are completed on admission and reviewed at least six monthly. Care plans demonstrate service integration and are individualised. There is a multidisciplinary approach in the evaluation of care plans six monthly. An improvement is required around the documentation of interventions to reflect the resident’s current health status. The diversional therapist provides an integrated activities programme for the residents that is varied, interesting, involves the families and community, entertainment and outings,
Storage, delivery and administration of medications meet medicine management requirements. Staff administering medication have completed medication competency assessments. There are improvements required around the standing orders document and self-medicating competency assessments.
Meals are prepared on site by a contracted catering company Medirest. Individual and special dietary needs are catered for and alternative choices offered. Food, fridge and freezer temperatures are recorded.

**Outcome 1.4: Safe and Appropriate Environment**

The facility has a current building Warrant of Fitness. There is a reactive and planned maintenance schedule. Clinical equipment and hoists are checked annually.

**Outcome 2: Restraint Minimisation and Safe Practice**

There is a documented definition of restraint and enablers which is congruent with the definition in NZS 8134.0. The policy includes comprehensive restraint procedures. The policy identifies that restraint is used as a last resort. The process of assessment and evaluation of enablers and restraint use is included in the policy. There are currently four residents using an enabler. There are four residents with restraint. There is an improvement required around aspects of enabler and restraint documentation.

**Outcome 3: Infection Prevention and Control**

The infection control co-ordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Summerset facilities.

## **Summary of Attainment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 13 | 0 | 4 | 0 | 0 | 0 |
| **Criteria** | 0 | 34 | 0 | 6 | 0 | 0 | 0 |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 33 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 61 |

## **Corrective Action Requests (CAR) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.2.3: Quality And Risk Management Systems | The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.3.5 | Key components of service delivery shall be explicitly linked to the quality management system. | PA Low | The quality meeting minutes do not consistently record key components of the quality management system such as internal audit results (and action plans), complaints, and incident reports and trending. | Key components of the quality management system are discussed and minuted at the monthly quality meetings. | 180 |
| HDS(C)S.2008 | Criterion 1.2.3.9 | Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;(b) A process that addresses/treats the risks associated with service provision is developed and implemented. | PA Low | The hazard register has a January 2013 date in the footer of the document, and there is no evidence of ongoing/annual review of the hazards listed. New hazards are reported on the appropriate form, however there is no evidence these hazards have either been eliminated or minimised and included on the main register. | The hazard register is reviewed at regular intervals. | 180 |
| HDS(C)S.2008 | Standard 1.3.6: Service Delivery/Interventions  | Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.6.1 | The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Low | 1) One hospital resident with repeat falls was referred to the physiotherapist in July 2014. There is no evidence of physiotherapist visit or referral follow-up made by the service; 2) a) There is no documented outcome of GP visit for hospital resident with unintentional weight, b) There are no documented interventions for one rest home resident with unintentional weight loss (now below target weight).; 3) There is no hourly monitoring in place (as per care plan) for resident with recent wandering behaviours.  | 1) Ensure physiotherapy referrals are followed up and occur, 2) Ensure unintentional weight loss interventions are documented, 3) Ensure monitoring requirements for challenging behaviours are implemented  | 60 |
| HDS(C)S.2008 | Standard 1.3.12: Medicine Management  | Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.12.1 | A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Low | The standing orders have not been reviewed since May 2014. The standing orders do not meet the standing order requirements. The GP reviewed and corrected the standing orders on the day of audit.  | Ensure standing orders are current and meet the standing order requirements.  | 60 |
| HDS(C)S.2008 | Criterion 1.3.12.5 | The facilitation of safe self-administration of medicines by consumers where appropriate. | PA Low | There is no formal competency assessment in place for the self-medicating residents  | Ensure competency assessments are completed for residents who self-medicate as per policy.   | 30 |
| HDS(RMSP)S.2008 | Standard 2.1.1: Restraint minimisation | Services demonstrate that the use of restraint is actively minimised.  | PA Low |  |  |  |
| HDS(RMSP)S.2008 | Criterion 2.1.1.4 | The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety. | PA Low | 1) Two enabler consent forms have been signed by the family. The two residents are unable to make a voluntary decision for the use of an enabler. 2) The initial assessment on admission does not identify the use of a restraint for one hospital resident admitted within the last three weeks. 3) Risks and monitoring frequency is not identified on the eight monitoring forms sampled.  | Ensure restraint and enabler forms and documentation are completed to meet the restraint minimization and safe practice standards.  | 90 |

## **Continuous Improvement (CI) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |

# NZS 8134.1:2008: Health and Disability Services (Core) Standards

## **Outcome 1.1: Consumer Rights**

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, facilitates informed choice, minimises harm, and acknowledges cultural and individual values and beliefs.

#### Standard 1.1.9: Communication **(**HDS(C)S.2008:1.1.9)

Service providers communicate effectively with consumers and provide an environment conducive to effective communication.

ARC A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1b.ii; D16.4b; D16.5e.iii; D20.3 ARHSS A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1bii; D16.4b; D16.53i.i.3.iii; D20.3

**Attainment and Risk:** FA

**Evidence:**

There is a policy to guide staff on the process around open disclosure. Accident/incident forms have a section to indicate if family have been informed (or not) of an accident/incident. Seven of seven incident forms reviewed across August identify family were notified following a resident incident. Interview with three caregivers (who work across the care centre), the nurse manager and one RN inform family are kept informed.

D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry
D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.
D16.4b relatives (two rest home and two hospital) stated that they are informed when their family members health status changes.
D11.3 The information pack is available in large print and this can be read to residents.

##### **Criterion 1.1.9.1 (HDS(C)S.2008:1.1.9.1)**

Consumers have a right to full and frank information and open disclosure from service providers.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.1.9.4 (HDS(C)S.2008:1.1.9.4)**

Wherever necessary and reasonably practicable, interpreter services are provided.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.1.13: Complaints Management  **(**HDS(C)S.2008:1.1.13)

The right of the consumer to make a complaint is understood, respected, and upheld.

ARC D6.2; D13.3h; E4.1biii.3 ARHSS D6.2; D13.3g

**Attainment and Risk:** FA

**Evidence:**

There is a complaints policy to guide practice. The village manager leads the investigation and management of complaints (verbal and written). All complaints are entered into ‘sway’ (Summerset way), the electronic database, where action taken and close out date is recorded. Complaints forms are visible around the facility. Interview with the village manager, and review of the electronic process indicates a total of nine complaints from care centre residents (including the rest home residents in the serviced apartments) have been received across the 2014 year. Of these, one remains open at the time of audit. There are a number of templates in the ‘sway’ system that can be used to manage complaints, such as an acknowledgement letter. Electronic notification is sent to the village manager if prescribed timelines are not being met.

Residents interviewed (two rest home) and relatives (two rest home and two hospital) confirm they are aware of how to make a complaint. There have been a number of compliments that have been received across the 2014 period.

D13.3h. a complaints procedure is provided to residents within the information pack at entry

##### **Criterion 1.1.13.1 (HDS(C)S.2008:1.1.13.1)**

The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.1.13.3 (HDS(C)S.2008:1.1.13.3)**

An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

## **Outcome 1.2: Organisational Management**

Consumers receive services that comply with legislation and are managed in a safe, efficient, and effective manner.

#### Standard 1.2.1: Governance **(**HDS(C)S.2008:1.2.1)

The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.

ARC A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.3d; D17.4b; D17.5; E1.1; E2.1 ARHSS A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.5

**Attainment and Risk:** FA

**Evidence:**

Summerset Napier provides care for up to 48 residents in the care centre across two service levels (rest home and hospital). On the day of audit there were 24 rest home residents and 23 hospital residents in the facility (one hospital level resident was in the DHB at the time of audit, making a total of 48). The care centre rooms have previously been assessed as dual purpose. Ten (of 20) serviced apartments have also previously been assessed as suitable for rest home level care (up to ten rest home residents) and at the time of audit there were three rest home residents in the apartments. This makes a total of 50 rest home/hospital residents in the facility at the time of audit.

There is a 2010-2015 Risk Management Plan, a Pandemic Health Plan and a 2014-2015 Business Plan. The Business Plan outlines organisational goals such as the provision of high quality nursing care and minimising clinical risk. One of the clinical targets linked to this goal is to reduce falls and skin tears by 20%. Each village then develops plan/s to achieve targets including date/s.

Summerset has a ‘clinical audit, training and compliance’ calendar that is being implemented at Summerset in the Bay. The calendar schedules the training and audit requirements for the month and the village manager completes a ‘best practice’ sheet confirming completion of requirements. The best practice sheet includes reporting including (but not limited to): meetings held, induction/orientation, audits, Careerforce, competencies, and projects. This is part of the ongoing monitoring programme. There is a monthly quality meeting at Summerset in the Bay.

The service is managed by a non-clinical village manager who has been in post just over a year. While he has a background in the hospitality industry, he worked in one of the Summerset village’s prior to this current role. He is supported by a nurse manager (registered nurse) who has been in post for approximately 1.5 years. The nurse manager has had approximately nine years’ experience in aged residential settings. There is a team of registered nurses and care staff.

ARC,D17.3di (rest home), D17.4b (hospital), the manager has maintained at least eight hours annually of professional development activities related to managing a hospital.

##### **Criterion 1.2.1.1 (HDS(C)S.2008:1.2.1.1)**

The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.1.3 (HDS(C)S.2008:1.2.1.3)**

The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.2.3: Quality And Risk Management Systems **(**HDS(C)S.2008:1.2.3)

The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.

ARC A4.1; D1.1; D1.2; D5.4; D10.1; D17.7a; D17.7b; D17.7e; D19.1b; D19.2; D19.3a.i-v; D19.4; D19.5 ARHSS A4.1; D1.1; D1.2; D5.4; D10.1; D16.6; D17.10a; D17.10b; D17.10e; D19.1b; D19.2; D19.3a-iv; D19.4; D19.5

**Attainment and Risk:** PA Low

**Evidence:**

Summerset in the Bay is implementing the organisation’s quality and risk management system. There are policies and procedures being implemented 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. Policies are reviewed on a regular basis. The content of policy and procedures are detailed to allow effective implementation by staff.

The Summerset group has a ‘clinical audit, training and compliance’ calendar that is being implemented at Summerset in the Bay. The calendar schedules the training and audit (etal) requirements for the month and the village manager completes a ‘best practice’ sheet confirming completion of requirements. The best practice sheet includes reporting including (but not limited to): meetings held, induction/orientation, audits, Careerforce, competencies, and projects.

There is a monthly quality meeting, the minutes do not consistently include discussion about clinical indicators (eg. incident trends, infection rates), complaints and internal audit. This is a required improvement. Summerset in the Bay infection control and health & safety committees both meet three monthly. While the health and safety meetings occur, there is no evidence of a review of the hazard register and this is an area for improvement. A report is provided to the quality meeting from these committee meetings. Information is then discussed at the weekly care staff/clinical update meetings and the monthly registered nurse meetings.

Resident/family meetings are held three monthly and are facilitated by an independent advocate. Residents also meet with management every three months. An annual survey has been completed and the 2013 results showed overall satisfaction as 87%. The 2014 survey was in process at the time of audit.

Summerset in the Bay is implementing an internal audit programme that includes aspects of clinical care – such as monthly file review. Issues arising from internal audits are developed into a corrective action plan. Corrective action plans are seen to have been closed out.

D19.3: There is a H&S and risk management programme in place including policies to guide practice. At the time of audit the office manager was the health and safety coordinator for the facility who, with the committee monitors accidents and incidents as part of the three monthly meeting.
D19.2g Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls. There is an organisational goal to reduce falls by 20% for the year.

##### **Criterion 1.2.3.1 (HDS(C)S.2008:1.2.3.1)**

The organisation has a quality and risk management system which is understood and implemented by service providers.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.3.3 (HDS(C)S.2008:1.2.3.3)**

The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.3.4 (HDS(C)S.2008:1.2.3.4)**

There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.3.5 (HDS(C)S.2008:1.2.3.5)**

Key components of service delivery shall be explicitly linked to the quality management system.

**Attainment and Risk:** PA Low

**Evidence:**

There are a range of meetings held by the facility including monthly quality meetings, three monthly health and safety, infection control and restraint meetings, monthly RN meetings and weekly care staff meetings. Reports from each area are taken to the quality meetings – i.e. Nurse Manager report, infection control report (etc.).

**Finding:**

The quality meeting minutes do not consistently record key components of the quality management system such as internal audit results (and action plans), complaints, and incident reports and trending.

**Corrective Action:**

Key components of the quality management system are discussed and minuted at the monthly quality meetings.

**Timeframe (days):** 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.3.6 (HDS(C)S.2008:1.2.3.6)**

Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.3.7 (HDS(C)S.2008:1.2.3.7)**

A process to measure achievement against the quality and risk management plan is implemented.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.3.8 (HDS(C)S.2008:1.2.3.8)**

A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.3.9 (HDS(C)S.2008:1.2.3.9)**

Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:
(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;
(b) A process that addresses/treats the risks associated with service provision is developed and implemented.

**Attainment and Risk:** PA Low

**Evidence:**

There are three monthly health and safety meetings that include discussion of hazards and accidents. New hazards are identified on a hazard report form. There is a hazard register in place.

**Finding:**

The hazard register has a January 2013 date in the footer of the document, and there is no evidence of ongoing/annual review of the hazards listed. New hazards are reported on the appropriate form, however there is no evidence these hazards have either been eliminated or minimised and included on the main register.

**Corrective Action:**

The hazard register is reviewed at regular intervals.

**Timeframe (days):** 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.2.4: Adverse Event Reporting  **(**HDS(C)S.2008:1.2.4)

All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.

ARC D19.3a.vi.; D19.3b; D19.3c ARHSS D19.3a.vi.; D19.3b; D19.3c

**Attainment and Risk:** FA

**Evidence:**

D19.3c: The service collects incident and accident data and reports aggregated figures monthly to the quality (and care staff) meeting (link 1.2.3). Incident forms are completed by staff, the resident is reviewed by the registered nurse at the time of event and the form is forwarded to the nurse manager for review and final sign off. Incidents are entered into sway. Family are notified. Seven incident forms were reviewed and all had been completed appropriately and signed off. One file was traced and reported incidents were noted to have been completed.

D19.3b; The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Trending data is considered, action plans have been developed following an increase in falls.

Discussions with service management, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications.

##### **Criterion 1.2.4.2 (HDS(C)S.2008:1.2.4.2)**

The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.4.3 (HDS(C)S.2008:1.2.4.3)**

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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.2.7: Human Resource Management  **(**HDS(C)S.2008:1.2.7)

Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.

ARC D17.6; D17.7; D17.8; E4.5d; E4.5e; E4.5f; E4.5g; E4.5h ARHSS D17.7, D17.9, D17.10, D17.11

**Attainment and Risk:** FA

**Evidence:**

There are human resources policies to support recruitment practices. A list of practising certificates is maintained. Seven staff files were reviewed (nurse manager, three caregivers, one registered nurse, the clinical nurse leader who is the infection control coordinator and restraint coordinator, recreation therapist) and all had relevant documentation relating to employment. Performance appraisals are current in all files reviewed. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme includes documented competencies and induction checklists (sighted in files of newly appointed staff). Staff interviewed (three caregivers, one registered nurse) were able to describe the orientation process and believed new staff were adequately orientated to the service. There is an annual education plan that is outlined on the ‘clinical audit, training and compliance calendar’. This includes all required education as part of these standards. The plan is being implemented. There is also an expectation care staff engage in the Careerforce programme – verified by three caregivers (who work across care centre and serviced apartments). A competency programme is in place with different requirements according to work type (e.g. caregiver, registered nurse, and kitchen). Core competencies are completed and a record of completion is maintained on staff files and well as being scanned into ‘sway’. Staff interviewed are aware of the requirement to complete competency training. Summerset employs a clinical education manager who is a registered nurse with a current practising certificate. She facilitates the orientation programme for new staff and support the ongoing education programme. There is a staff member with a current first aid certificate on every shift.

##### **Criterion 1.2.7.2 (HDS(C)S.2008:1.2.7.2)**

Professional qualifications are validated, including evidence of registration and scope of practice for service providers.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.7.3 (HDS(C)S.2008:1.2.7.3)**

The appointment of appropriate service providers to safely meet the needs of consumers.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.7.4 (HDS(C)S.2008:1.2.7.4)**

New service providers receive an orientation/induction programme that covers the essential components of the service provided.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.7.5 (HDS(C)S.2008:1.2.7.5)**

A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.2.8: Service Provider Availability  **(**HDS(C)S.2008:1.2.8)

Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.

ARC D17.1; D17.3a; D17.3 b; D17.3c; D17.3e; D17.3f; D17.3g; D17.4a; D17.4c; D17.4d; E4.5 a; E4.5 b; E4.5c ARHSS D17.1; D17.3; D17.4; D17.6; D17.8

**Attainment and Risk:** FA

**Evidence:**

The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. Staffing is as follows: village manager and nurse manager – both full-time Monday to Friday.

Clinical Nurse Leader (RN) – Sunday to Thursday 0645-1515, this position is replaced by an RN Friday and Saturday

AM: 1x registered nurse, 4 care givers 0700-1500, 1 caregiver 0800-12midday, 2 caregiver 0700-1300, 1 caregiver serviced apartments

PM: 1x registered nurse, 3 caregivers 1500-2300, 1 caregiver 1600-2100, 1 caregiver 1500-2200, 1 caregiver serviced apartments

ND: 1x registered nurse, 2 caregiver 2300-0700, serviced apartments are covered by care centre staff.

There is at least one registered nurse and one first aid qualified person on each shift. The caregivers, residents and relatives interviewed inform there are sufficient staff on duty at all times.

##### **Criterion 1.2.8.1 (HDS(C)S.2008:1.2.8.1)**

There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

## **Outcome 1.3: Continuum of Service Delivery**

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.

#### Standard 1.3.3: Service Provision Requirements **(**HDS(C)S.2008:1.3.3)

Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.

ARC D3.1c; D9.1; D9.2; D16.3a; D16.3e; D16.3l; D16.5b; D16.5ci; D16.5c.ii; D16.5e ARHSS D3.1c; D9.1; D9.2; D16.3a; D16.3d; D16.5b; D16.5d; D16.5e; D16.5i

**Attainment and Risk:** FA

**Evidence:**

D.16.2, 3, 4: The five resident files sampled (three hospital and two rest home – one in serviced apartment) identified that the registered nurse (RN)s complete an initial assessment within 24 hours. Information gathered on admission from needs assessment form, discharge summaries, nursing care discharge summaries, GP health records and letters, allied health notes, resident/family/whanau participation and involvement provide the basis for the initial assessment and initial support care plan. All five files sampled identified that the long term resident centred care plan (RCCP) is developed within three weeks. All five RCCPs sampled are signed and dated by the RN keyworker. Families (two rest home and two hospital) and residents (two rest home) confirmed on interview they are invited to attend care plan reviews and GP visits. The recreational therapist completes an activity assessment and activity plan in consultation with the resident/family/whanau as appropriate.
D16.5e: Five of five resident files sampled identified that the general practitioner (GP) had seen the resident within two working days. It was noted in all resident files sampled that the GP had examined the resident three monthly and carried out a medication review. More frequent medical review is evidenced in files of residents with more complex conditions or acute changes to health status. The service has a contracted GP however residents may choose to retain their own GP. The GP (interviewed) states there is good continuity of medical care with 2 visits per week and at other times as required. The GP is available up until 8pm and 24/7 for palliative care patients. A designated GP at the medical centre will provide locum cover as required. The GP receives good feedback from the residents and families on the services provided at Summerset in the Bay. The GP attends the multidisciplinary review meetings with the families and staff. There are no concerns with enrolling new patients. All five resident files sampled identified integration of allied health professionals and a team approach.

There is a verbal handover at the beginning of each shift to the caregivers to ensure staff are kept informed of resident’s health status and any significant events. Handover also includes any policy reviews/updates and brief in-service as applicable.

A physiotherapist is contracted for three hours a week however this is flexible to ensure all residents requiring physiotherapy input/assessments/referrals as per the weekly physio list of residents are seen. The physiotherapist is involved in the multidisciplinary team (MDT) reviews. A podiatry service is available.

Tracer methodology rest home resident in serviced apartment.

XXXXXX This information has been deleted as it is specific to the health care of a resident.

Tracer methodology hospital resident with frequent falls and weight loss:

XXXXXX This information has been deleted as it is specific to the health care of a resident.

##### **Criterion 1.3.3.1 (HDS(C)S.2008:1.3.3.1)**

Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.3.3.3 (HDS(C)S.2008:1.3.3.3)**

Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.3.3.4 (HDS(C)S.2008:1.3.3.4)**

The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.3.5: Planning  **(**HDS(C)S.2008:1.3.5)

Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.

ARC D16.3b; D16.3f; D16.3g; D16.3h; D16.3i; D16.3j; D16.3k; E4.3 ARHSS D16.3b; D16.3d; D16.3e; D16.3f; D16.3g

**Attainment and Risk:** FA

**Evidence:**

Five resident files (three hospital and two rest home) sampled identified documented interventions to meet the resident’s needs of daily living.

##### **Criterion 1.3.5.2 (HDS(C)S.2008:1.3.5.2)**

Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.3.6: Service Delivery/Interventions  **(**HDS(C)S.2008:1.3.6)

Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.

ARC D16.1a; D16.1b.i; D16.5a; D18.3; D18.4; E4.4 ARHSS D16.1a; D16.1b.i; D16.5a; D16.5c; D16.5f; D16.5g.i; D16.6; D18.3; D18.4

**Attainment and Risk:** PA Low

**Evidence:**

The RN assesses all residents on admission and completes individualised care plans. When a resident's condition alters, the registered nurses initiate a review and if required, GP or specialist consultation. Four family members (two rest home and two hospital) state their relative’s needs are being met.
A range of assessment tools are completed on admission and reviewed at least six monthly as applicable and include (but not limited to); continence, falls assessment and safe manual handling, waterlow pressure area, pain assessment, wound, MUST nutritional, assessment and dietary requirements, cultural needs assessment and activity initial assessment.
D18.3 Dressing supplies are available and adequate supplies of wound care products, blood glucose monitoring equipment and other medical equipment is sighted. There are adequate supplies of incontinent products in all areas.
Initial wound assessment and ongoing treatment/management plans are in place for five skin tears and one leg ulcer. There is two grade 1 pressure areas (back of leg and heel). Wound mapping and photos are in place for chronic wounds. Short term care plans are in place. This is an improvement from the previous audit. The pressure areas are linked to care plans with pressure area interventions documented in the care plan. There are adequate pressure area resources in place and ongoing monitoring and interventions such as two hourly turning. The service has access to the DHB wound nurse as required.

Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day and night use. Specialist continence advice is available as needed. All risk wound and continence assessments are dated. This is an improvement from the previous audit.

All falls are reported on the resident accident/incident form. Falls risk assessments and safe manual handling assessments are completed on admission and reviewed at least six monthly or earlier if required. The use of a repetitive falls screening tool identifies falls management prevention strategies and resources required such as ultra-low beds, sensor mats, uncluttered rooms and hip protectors. There is evidence of physiotherapist referrals post falls however there is an improvement required to ensure referrals are actioned within a timely manner.

Resident’s weight is recorded on admission and monitored monthly. Chair scales are available and have been calibrated (March 2014). MUST nutritional screening is completed for residents identified with weight loss. There is an improvement required around the documentation of weight loss interventions.

Altered behaviours are reported and monitored on behaviour logs. The GP is notified and any medical causes excluded. There is evidence of referrals to mental health services for ongoing behaviours. There is an improvement required around monitoring requirements.

##### **Criterion 1.3.6.1 (HDS(C)S.2008:1.3.6.1)**

The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.

**Attainment and Risk:** PA Low

**Evidence:**

All falls are reported on the resident accident/incident form. Falls risk assessments and safe manual handling assessments are completed on admission and reviewed at least six monthly or earlier if required. The use of a repetitive falls screening tool identifies falls management prevention strategies and resources required such as ultra-low beds, sensor mats, uncluttered rooms and hip protectors. Residents with repeat falls are referred to the physiotherapist.

Resident’s weight is recorded on admission and monitored monthly. Chair scales are available and have been calibrated (March 2014). MUST nutritional screening is completed for residents identified with weight loss.

Altered behaviours are reported and monitored on behaviour logs. The GP is notified and any medical causes excluded. There is evidence of referrals to mental health services for ongoing behaviours.

**Finding:**

1) One hospital resident with repeat falls was referred to the physiotherapist in July 2014. There is no evidence of physiotherapist visit or referral follow-up made by the service; 2) a) There is no documented outcome of GP visit for hospital resident with unintentional weight, b) There are no documented interventions for one rest home resident with unintentional weight loss (now below target weight).; 3) There is no hourly monitoring in place (as per care plan) for resident with recent wandering behaviours.

**Corrective Action:**

1) Ensure physiotherapy referrals are followed up and occur, 2) Ensure unintentional weight loss interventions are documented, 3) Ensure monitoring requirements for challenging behaviours are implemented

**Timeframe (days):** 60 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.3.7: Planned Activities **(**HDS(C)S.2008:1.3.7)

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.

ARC D16.5c.iii; D16.5d ARHSS D16.5g.iii; D16.5g.iv; D16.5h

**Attainment and Risk:** FA

**Evidence:**

A qualified Diversional Therapist (DT) is employed for 35 hours per week and is supported by a recreational therapist 15 hours per week who has a health and physical education qualification. Both attend the regional DT meetings and workshops three monthly and have first aid certificates. The rest home and hospital programme is integrated and covers seven days. The hours for the programme are 10am-3.30pm. There are two activity staff on Tuesdays. There is a separate programme for the care apartments and village. Rest home residents in serviced apartments can choose to attend the rest home/hospital or village programme. The programme is planned a month in advance and follows a set plan that is also flexible to meet the preferences and recreational needs of the group and individual needs. There is a monthly theme with this month’s being “spring”. Birthdays and events such as father’s day recently are celebrated. Volunteers are involved in one on one resident time and assisting with activities. There are weekly entertainers. Church services are held weekly. Community links are maintained with outings to cafes, RSA, shopping and places of interest and a buddy system with school children visiting the home. The service has a wheelchair van. Two staff accompany residents on outings. The programme is tailored to meet the differing needs of the residents and includes (but not limited to); newspaper reading, short stories, jigsaws, puzzles, crosswords, crafts, exercise (armchair, balloon), Tai Chi, manicures, knit and natter group, walking group, baking, sand art, happy hour and pet therapy on Sundays. Music plays throughout the day.

A resident advocacy meeting is held every three months. A resident meeting is held monthly where feedback is provided on the activity programme and suggestions for outings.

Activity assessments, cultural and communication assessments are completed with resident/family/whanau involvement. Each resident has an individual activity plan. The resident/family are involved in the care plan reviews which occur at the same time as the review of the clinical care plan. Individual activity participation records are maintained.

##### **Criterion 1.3.7.1 (HDS(C)S.2008:1.3.7.1)**

Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.3.8: Evaluation  **(**HDS(C)S.2008:1.3.8)

Consumers' service delivery plans are evaluated in a comprehensive and timely manner.

ARC D16.3c; D16.3d; D16.4a ARHSS D16.3c; D16.4a

**Attainment and Risk:** FA

**Evidence:**

There is documented evidence of written multidisciplinary reviews held six monthly involving the resident/family/whanau, RN, nurse manager, restraints officer, diversional therapist, primary caregiver, and where applicable allied health input such as the physiotherapist. The previous audit finding regarding six monthly evaluations has been addressed. The RNs amend the long term support plan to reflect ongoing changes as part of the review process. Allied health professionals involved in the residents care are linked to the resident centred care plan review such as, dietitian, physiotherapist, podiatrist, social worker and mental health services. Allied health notes are maintained in the residents file. All five resident files sampled documented discussions with family/whanau regarding changes to health, incidents, infections, MDT meetings (care plan review), and GP visits. A copy of the review is sent to the family if they are unable to attend. There are short term care plans in place for short term needs such as skin tears, bruising, wounds and infections. Short term care plans have been evaluated regularly and either resolved or if an ongoing problem included in the long term resident centred care plan.

##### **Criterion 1.3.8.2 (HDS(C)S.2008:1.3.8.2)**

Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.3.8.3 (HDS(C)S.2008:1.3.8.3)**

Where progress is different from expected, the service responds by initiating changes to the service delivery plan.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.3.12: Medicine Management  **(**HDS(C)S.2008:1.3.12)

Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.

ARC D1.1g; D15.3c; D16.5e.i.2; D18.2; D19.2d ARHSS D1.1g; D15.3g; D16.5i..i.2; D18.2; D19.2d

**Attainment and Risk:** PA Low

**Evidence:**

The service uses individualised robotic packs for regular medications. PRN medications are dispensed in bottles. The medications are delivered monthly and signed off on the medication reconciliation form (sighted). PRN medications are checked monthly for expiry dates. There is one main medication room for the rest home and hospital. All pharmaceuticals are stored safely within the locked treatment room. RN’s only administer medications and have completed annual competency assessments and attended annual medication education delivered by the pharmacist in July 2014. All RNs hold syringe driver certification. Caregivers complete competencies for the checking of controlled drugs. Hospital level drugs are held in the drug safe. The controlled drugs are checked weekly and a pharmacy audit completed six monthly. There is an improvement required to the standing order form. There are two residents in the rest home that self-administer eye drops and inhalers. There is an improvement required around resident self-medication assessments. The pharmacy returns box is kept in the locked treatment room. All eye drops are dated on opening. The medication fridge temperature is recorded weekly. Emergency oxygen and suction is available. There is an approved container for the disposal of sharps. Clinical monitoring equipment has been calibrated.
Ten medication signing sheets are sampled and all correct with no gaps. Medication administration observed the signing of non-packaged medications occurred on administration. This is an improvement since the previous audit. Two staff sign for the administration of controlled drugs. There is a prn medication administration sheet that details date, time, medication given, strength, route, indication, effectiveness, comments and signature. There are blood sugar monitoring and insulin administration sheets and anticoagulant monitoring forms and dosages. Pain assessment charts are held in the medication folder. Duplicate name labels and special instructions for resident administration are used.
All prescribed medications on the 10 medication charts sampled are signed by the GP. All medication charts had photo identification and allergies documented. The service has in place policies and procedures for ensuring all medicine related recording and documentation is: a) legible, b) signed and dated and c) able to meet acceptable good practice standards.
D16.5.e.i.2; Ten medication charts reviewed identified that the GP had seen the reviewed the resident medications three monthly.

##### **Criterion 1.3.12.1 (HDS(C)S.2008:1.3.12.1)**

A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.

**Attainment and Risk:** PA Low

**Evidence:**

There is one main medication room for the rest home and hospital. All pharmaceuticals are stored safely within the locked treatment room. RN’s only administer medications and have completed annual competency assessments and attended annual medication education delivered by the pharmacist in July 2014. There are standing order in use. Ten medication signing sheets are sampled and all correct with no gaps. Medication administration observed the signing of non-packaged medications occurred on administration. This is an improvement since the previous audit.

**Finding:**

The standing orders have not been reviewed since May 2014. The standing orders do not meet the standing order requirements. The GP reviewed and corrected the standing orders on the day of audit.

**Corrective Action:**

Ensure standing orders are current and meet the standing order requirements.

**Timeframe (days):** 60 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.3.12.3 (HDS(C)S.2008:1.3.12.3)**

Service providers responsible for medicine management are competent to perform the function for each stage they manage.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.3.12.5 (HDS(C)S.2008:1.3.12.5)**

The facilitation of safe self-administration of medicines by consumers where appropriate.

**Attainment and Risk:** PA Low

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):** 30 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.3.12.6 (HDS(C)S.2008:1.3.12.6)**

Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.3.13: Nutrition, Safe Food, And Fluid Management **(**HDS(C)S.2008:1.3.13)

A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.

ARC D1.1a; D15.2b; D19.2c; E3.3f ARHSS D1.1a; D15.2b; D15.2f; D19.2c

**Attainment and Risk:** FA

**Evidence:**

Food services at Summerset is contracted to Medirest. There is a chef/manager on Monday to Friday and a Sous chef Friday to Monday. They are supported by a kitchen assistant 9.30am-5.30pm and a kitchen dishwasher 5.30-7pm daily. The company dietitian is currently reviewing the summer menu. There is an on-line ordering systems and recipes (including nutritional values and portion sizes) for all of the Summerset facilities. Medirest also manages the on-site café. The chef receives dietary requirements forms for new residents that describes special diets, likes and dislikes. A dislikes board is maintained and alternative choices are offered as required. The chef manager (interviewed) is notified of any dietary changes and is aware of any residents with weight loss. Nutritional drinks and high calorie diets are offered. Normal, pureed, gluten free and diabetic meals are provided. All foods are cooked on site. End point cooking temperatures are checked and recorded daily (sighted). Meals are delivered to the rest home and hospital kitchenettes in heated trolleys. Trays are transported in hot boxes to residents who choose to have meals in rooms. Temperatures of meals have been identified in resident advocate meeting minutes (June 2014) and management meeting minutes (July 2014. The service was able to show that these concerns are being addressed. The kitchen is well equipped with freezers, fridges and walk-in chiller. There is daily recording of the chiller and freezers and dishwasher temperatures. The dry foods in the pantry are all off the floor, sealed and labelled with expiry dates. Foods are labelled in the fridges and chiller. Kitchen cleaning schedules are in place and signed as cleaning duties are completed (sighted). Chemicals are stored in a locked cupboard. There is a chemical spills kit available. Contractors are available 24/7 to service kitchen equipment as required. Feedback is received through the resident meetings, medirest surveys, meeting with the village manager and area manager.

D19.2 . All Staff are scheduled to attend NZQA 167 unit standard 30 September 2014. Staff have attended chemical safety training in May 2014.

##### **Criterion 1.3.13.1 (HDS(C)S.2008:1.3.13.1)**

Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.3.13.2 (HDS(C)S.2008:1.3.13.2)**

Consumers who have additional or modified nutritional requirements or special diets have these needs met.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.3.13.5 (HDS(C)S.2008:1.3.13.5)**

All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

## **Outcome 1.4: Safe and Appropriate Environment**

Services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensures 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.

#### Standard 1.4.2: Facility Specifications  **(**HDS(C)S.2008:1.4.2)

Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.

ARC D4.1b; D15.1; D15.2a; D15.2e; D15.3; D20.2; D20.3; D20.4; E3.2; E3.3e; E3.4a; E3.4c; E3.4d ARHSS D4.1c; D15.1; D15.2a; D15.2e; D15.2g; D15.3a; D15.3b; D15.3c; D15.3e; D15.3f; D15.3g; D15.3h; D15.3i; D20.2; D20.3; D20.4

**Attainment and Risk:** FA

**Evidence:**

The facility has a current building warrant of fitness that expires on 1 August 2015. There is a reactive and planned maintenance programme. Electrical equipment has been tested and tagged August 2014. Clinical equipment has been calibrated. Hot water temperatures are monitored randomly in each wing and records show stable temperatures at acceptable ranges.

##### **Criterion 1.4.2.1 (HDS(C)S.2008:1.4.2.1)**

All buildings, plant, and equipment comply with legislation.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

# NZS 8134.2:2008: Health and Disability Services (Restraint Minimisation and Safe Practice) Standards

## **Outcome 2.1: Restraint Minimisation**

Services demonstrate that the use of restraint is actively minimised.

#### Standard 2.1.1: Restraint minimisation **(**HDS(RMSP)S.2008:2.1.1)

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

**Attainment and Risk:** PA Low

**Evidence:**

There is a documented definition of restraint and enablers which is congruent with the definition in NZS 8134. The policy identifies that restraint is used as a last resort. There is a checklist of alternative approaches and/or interventions that could be used to minimise restraint usage. The restraint co-ordinator (RN) has been in the role since July 2013. Staff receive restraint training at orientation and is ongoing. Staff complete restraint competencies and restraint is discussed at clinical meetings.

There are 4 enablers (bedrails) in use for four hospital residents. There is an improvement required to ensure the use of an enabler is a voluntary decision. There are four restraints in use for four hospital residents. An enabler and restraint register is maintained. Enabler and restraint consents and assessments are completed and reviewed three monthly with the restraint co-ordinator and GP. The use of enablers and restraints are identified in the resident long term care plan. There is an improvement required to identify the use of a restraint on admission. Monitoring is in place for enablers and restraints. There is an improvement required regarding the monitoring forms.

##### **Criterion 2.1.1.4 (HDS(RMSP)S.2008:2.1.1.4)**

The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.

**Attainment and Risk:** PA Low

**Evidence:**

There are four enablers (bedrails) in use for four hospital residents. Enabler consent forms are in place. Enabler and restraint consents and assessments are completed and reviewed three monthly with the restraint co-ordinator and GP. The use of enablers and restraints are identified in the resident long term care plan. There is an improvement required to identify the use of a restraint on admission. Monitoring is in place for enablers and restraints.

**Finding:**

1) Two enabler consent forms have been signed by the family. The two residents are unable to make a voluntary decision for the use of an enabler. 2) The initial assessment on admission does not identify the use of a restraint for one hospital resident admitted within the last three weeks. 3) Risks and monitoring frequency is not identified on the eight monitoring forms sampled.

**Corrective Action:**

Ensure restraint and enabler forms and documentation are completed to meet the restraint minimization and safe practice standards.

**Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

# NZS 8134.3:2008: Health and Disability Services (Infection Prevention and Control) Standards

#### Standard 3.5: Surveillance **(**HDS(IPC)S.2008:3.5)

Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.

**Attainment and Risk:** FA

**Evidence:**

Infection monitoring is the responsibility of the infection control coordinator. The infection control policy describes routine monthly infection surveillance and reporting. Responsibilities and assignments are described and documented. The surveillance activities at Summerset in the Bay are appropriate to the acuity, risk and needs of the residents. The infection control coordinator enters infections on to the infection register and into the ‘sway’ database, which generates a monthly analysis of the data. The analysis is reported to the monthly quality meetings (link 1.2.3). The general practitioner interviewed confirmed that staff provide information about any changes in state for a resident including if there are infections and confirms that instructions are followed up. There is evidence of general practitioner involvement and laboratory reporting in the resident files reviewed.

##### **Criterion 3.5.1 (HDS(IPC)S.2008:3.5.1)**

The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 3.5.7 (HDS(IPC)S.2008:3.5.7)**

Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*