# Summerset Care Limited - Summerset by the Ranges

## Current Status: 9 October 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

Summerset by the Ranges currently provides rest home and hospital level care for up to 30 residents. On the day of audit, there was full occupancy with 22 rest home residents and eight hospital residents.

Summerset by the Ranges has a business and quality risk management plan. The village manager is an experienced manager with a wide range of relevant experiences. She is supported by the nurse manager who was newly appointed to this role in June 2014.

The required corrective actions from the previous audit in relation to the provision of hospital level care, staffing and access to outdoor areas have been addressed.

This audit identified further improvements required around implementation of corrective action plans following meetings and implementation of the medication management system.

## Audit Summary as at 9 October 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 9 October 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 9 October 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 9 October 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 9 October 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 9 October 2014

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

### Infection Prevention and Control as at 9 October 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 by the Ranges |

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

|  |  |
| --- | --- |
| **Types of audit:** | Surveillance Audit |
| **Premises audited:** | Summerset by the Ranges |
| **Services audited:** | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) |
| **Dates of audit:** | **Start date:** | 9 October 2014 | **End date:** | 10 October 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:** | 30 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXXXX | **Hours on site** | 13 | **Hours off site** | 6 |
| **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** | 2 |

## **Sample Totals**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 13 | Total audit hours off site | 8 | Total audit hours | 21 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 5 | Number of staff interviewed | 8 | Number of managers interviewed | 2 |
| Number of residents’ records reviewed | 5 | Number of staff records reviewed | 6 | Total number of managers (headcount) | 2 |
| Number of medication records reviewed | 12 | Total number of staff (headcount) | 35 | Number of relatives interviewed | 3 |
| Number of residents’ records reviewed using tracer methodology | 2 |  |  | Number of GPs interviewed |  |

## **Declaration**

I, XXXXXXX, 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 Thursday, 6 November 2014

## **Executive Summary of Audit**

**General Overview**

Summerset by the Ranges currently provides rest home and hospital level care for up to 30 residents. On the day of audit the service was fully occupied and they were 22 rest home residents and eight hospital residents.

Summerset by the Ranges has a business and quality risk management plan and goals for 2014. The village manager is an experienced manager who has wide range of experiences in public services, social work, social development, civil defence, and human resources management. She is supported by the nurse manager who has been newly appointed to this role (June 2014).

The service withdraw the application to provide rest home level care in the services apartments therefore required corrective actions from the previous audit relating to this are not required.

The required corrective actions from the previous audit in relation to provision of hospital level care, staffing and access to outdoor areas have been addressed.

This audit identified further improvements required around implementation of corrective action plans following meetings and implementation of medication management system.

**Outcome 1.1: Consumer Rights**

Open disclosure is included in relevant policies and procedures to ensure full and frank open disclosure. Review of documents and discussion with families identifies that they are always notified of incidents/accidents affecting their family members. The service continues to conduct residents meeting with an advocate. Any issues or concerns to residents are discussed in these meetings and follow –up is completed by the village manager. Annual resident and relative surveys are also completed. Residents and relatives survey 2014 shows overall 99% satisfaction.

Complaints are recorded in the online register and there are no complaints documented for the care centre for 2014.

**Outcome 1.2: Organisational Management**

Summerset by the Ranges has a site-specific business and quality risk management plan and goals for 2014. The internal auditing program is designed to monitor contractual and standards’ compliance and the quality of service delivery in the facility and across the organization. The reviews of this program reflect the service’s ongoing progress around quality improvement. All quality data is entered in to the Summerset database management system “Sway- The Summerset Way” which collects all data from each summerset side and generates site specific analysis reports. Benchmarking with other summerset facilities occur and benchmarking data obtained through Sway. There is a 2014 clinical audit, training and compliance calendar which is implemented. Incidents and accidents are reported, analyzed and recorded on a monthly summary sheet. Hazards are reported and the hazard register is reviewed annually. There is an improvement required around implementation of identified corrective action plans following meetings.

Summerset by the Ranges has comprehensive and well implemented human resource management processes. Recruitment process is implemented and all required documentation is maintained in the staff file or digital copy is also available, therefore required corrective actions from the previous audit have been addressed. The human resources planning document provides the rationale for staffing and skill mix. Staffing level is adjusted according to the company policy and based on resident’s acuity. Caregivers reported that staffing levels and the skill mix are appropriate and safe. All family interviews confirmed that transition to the hospital level care is well managed and families felt that staffing level is sufficient. The village manager or the nurse manger on-call at all times, that at least one staff member on duty hold a current first aid qualification. Previous audit finding around 24 hour RN cover and employment of nurse manager have been actioned. The service withdraw the application to provide rest home level care in the serviced apartments therefore the previous corrective action around 24 hour caregiver cover in the service apartments is not required.

**Outcome 1.3: Continuum of Service Delivery**

A review of five resident files identified that there is sufficient information gained through the initial resident short term care plan, specific assessments, the short-term treatment plan, and the long term care plan to guide staff in the safe delivery of care to residents. Files document allied health input and involvement of relatives and a team approach is evident. Changes to the long term care plan are made as required and at the six monthly review if required. Activities are well planned and appropriate. The activity program is run by the diversional therapist who has been with Summerset over 3 years. She works Tuesday to Saturday for a total of 30 hours each week. The activities program includes 7 days a week and caregivers implements the program when the DT is not on duty. The service has a Van and outings are provided three times a week. Residents can be transported and this allows them to remain integrated in the community.

Food is prepared on site and food service is contracted. The kitchen is well maintained and clean. A weekly rolling menu is implemented. Required changes to summer and winter menu are approved by the contracted company dietician. A copy of residents nutritional profiles are maintained in the kitchen. Resident’s food satisfactions are followed.

There are policies and protocols to manage the safe and appropriate prescribing, dispensing, administration, review, storage and disposal of medicines in order to comply with legislation, regulations and guidelines. There are 10 medication competent caregivers but since beginning of hospital level care provision, medications are administered by the RNs. Resident medications are reviewed by the residents’ general practitioner at least three monthly. There is an improvement required around implementation of medication management system.

**Outcome 1.4: Safe and Appropriate Environment**

There is a current building warrant of fitness that expires on July 2015. Maintenance plan is implemented. The property manager oversees maintenance across the facility, apartments and village. Required corrective action around safe outdoor access has been addressed.

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

There are policies around restraint, enablers and the management of challenging behaviours. Summerset by the Ranges does not currently use restraint or enablers. Policy dictates that enablers should be voluntary and the least restrictive option possible.

Staff received training around restraint minimization and the management in challenging behaviour is completed in May 2014 which was around implementation of policies.

**Outcome 3: Infection Prevention and Control**

The infection control coordinator is responsible for coordinating and providing education and training for staff. Infection control data is collated monthly and trends and analysis of infections are discussed at the quality improvement/staff meetings. Action is taken to reduce the infection rates according to surveillance results and any issues of urgency are dealt with in a timely manner. The results from infection control data analysis are benchmarked against other Summerset facilities.

## **Summary of Attainment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 14 | 0 | 2 | 0 | 0 | 0 |
| **Criteria** | 0 | 39 | 0 | 2 | 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 | 34 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 60 |

## **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 1.2.3.8 | A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | PA Low | Corrective actions are not routinely followed through in meeting minutes. The meeting minute’s format has been changed in last three months and issues do not follow meeting to meeting. There was no documented evidence that corrective actions identified through meetings are actioned. Meeting minutes form has a section where the sign off is documented. This part of the form is not completed routinely.  | Ensure that identified corrective actions are implemented and signed off when completed. | 180 |
| 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 | (i)A resident was admitted from the public hospital and current medications were changed and this was identified in the discharge report. This change was faxed to the contracted pharmacy and medication was administered against the original medication script provided by the hospital. Medication administered on the day of audit is correct against the hospital medication script however, signing sheets do not match with the current script and the medication chart updated by the GP has two copies (one being the original chart) and these two charts also do not match including start date of medications. (ii) Two out of 12 medication signing sheets have medication signing gaps. (iii) On one chart, two medications were stopped (crossed over) by the GP but the stop date was not documented and also not signed by the GP. | Ensure that medications are reconciled when a resident re-admitted to the facility. Ensure that medication is signed as administered. Ensure that discontinued medications are dated and signed by the GP. | 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:**

Open disclosure is included in relevant policies and procedures to ensure full and frank open disclosure. Records for five residents (three rest home and two hospital) and 17 accident/incident forms demonstrate that residents and their families are kept informed of situations that impact them and open communication is maintained. Five resident interviews (three rest home and two hospital) and three family interviews (one hospital and two rest home) demonstrate satisfaction with open disclosure practices.

Discussions with three caregivers and two registered nurses (RN) confirmed that open disclosure principles are implemented.

The service continues to conduct residents’ and advocacy meetings. Any issues or concerns to residents are discussed in these meetings and follow –up is completed by the Village manager. Annual resident and relative surveys are also completed. Residents and relatives survey 2014 shows overall 99% satisfaction.

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: Three family members stated that they are always informed when their family members health status changes.

'D11.3: The information pack is available in large print and advised that 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:**

Complaints are recorded in the Sway (Summerset database management system “Sway- The Summerset Way”) and complaint register includes the village complaints. These include good documentation, actions taken, follow up and resolution. There are no complaints documented for the care centre for 2014.

Two RN s interviewed stated that they are aware of documentation requirement of verbal complaint but they did not have any. Caregiver interviews also confirmed this.

Discussions with three relatives (one hospital and two rest home) that they feel comfortable to bring up any concerns or issues but have not made any complaints in the past.

Discussions with three rest home and two hospital residents confirmed that they are able to raise concerns and issues with staff or the RN and stated that they also did not make any complaints to the date.

##### **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 by the Ranges currently provides rest home and hospital level care for up to 30 residents. On the day of audit the service was fully occupied and they were 22 rest home residents and eight hospital residents.

Summerset by the Ranges implements the Summerset wide quality and risk programme There is also a site-specific business and quality risk management plan and goals for 2014 which link to the Summerset wide programme.

The village manager is an experienced manager who has wide range of experiences in public services, social work, social development, civil defence, and human resources within a district health board. She holds a public services degree and human resource post graduate degree. The village manager has responsibility for non-clinical services and she has attended at least eight hours of professional development relevant to the role. She is supported by the nurse manager who has been newly appointed to this role (June 2014). She is an overseas trained RN with eight years of experience in aged care in NZ. She had previously held charge nurse position in another aged care facility. The nurse manager completed her orientation and familiar with company policy and procedures. Policies and procedures are developed at an organisational level with input from staff and external specialist expertise where required. There is an operations manager who is available to support the facility and staff.

##### **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 by Ranges has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001.

The internal auditing program is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organization. The reviews of this program reflect the service’s ongoing progress around quality improvement.

Summerset by the Ranges implements the Summerset wide quality and risk programme. There is also a site-specific business and quality risk management plan and goals for 2014 which link to the Summerset wide programme.

Discussions with the village manager confirmed that the management team and all staff have shared responsibility in implementation of the quality management program. Quality data is reported through the monthly quality improvement and staff meetings, and key components of the programme includes audit, infection control and prevention, incidents, complaints, training, restraint minimization and health and safety. Information is then reported back to the staff meeting.

Incidents and accidents are reported, analyzed and recorded on a monthly summary sheet. Complaints are documented in the complaints register. An infection rate monthly summary is completed. Hazards are reported and the hazard register is reviewed annually. All quality data is entered in to the Sway which collects all data from each summerset side and generates site specific analysis reports.

Benchmarking with other summerset facilities occur and benchmarking data obtained through Sway.

There is a 2014 clinical audit, training and compliance calendar which is implemented.

Consumer satisfaction survey is completed in 2014 and shows 99% satisfaction. Benchmarking data shows that although the response rate was low, Summerset by Ranges had highest satisfaction level across the Summerset facilities in nationwide.

Resident meetings occur three monthly and an independent advocate sits in these meetings.

There is a monthly teleconference with Summerset head office that includes discussions around quality improvements and new initiatives across the Summerset facilities. Corrective actions are not routinely followed through in meeting minutes. The meeting minute’s format has been changed in last three months and issues do not follow meeting to meeting. There was no documented evidence that corrective actions identified through meetings are actioned. Meeting minutes form has a section where the sign off is documented. This part of the form is not completed routinely.

There is an organisational clinical group that meets and review policies and procedures and best practice. There is a document control policy that includes clear guidelines for review and amended policies.

D19.3: There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management.

D19.2g: Fall prevention strategies are in place that includes the analysis of falls incidents and ongoing assessments of residents who is identified as high risk. There is also Vitamin D falls prevention project that cover 82% participation. Residents identified as high falls-risk have following interventions in place, a) the use of hip protectors, b) hi/lo beds, c) nursing assessment d) sensor mats and e) close staff supervision.

Six out of six staff interviewed (two RNs and three care givers, and a DT) confirm quality improvement data is reviewed at their staff and quality improvement meetings.

##### **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:** 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 1.2.3.6 (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:** PA Low

**Evidence:**

Summerset continues to collect data to support the implementation of corrective action plans. Responsibilities for corrective actions are identified.

Audit results are analysed and where corrective actions are identified has been followed up.

**Finding:**

Corrective actions are not routinely followed through in meeting minutes. The meeting minute’s format has been changed in last three months and issues do not follow meeting to meeting. There was no documented evidence that corrective actions identified through meetings are actioned. Meeting minutes form has a section where the sign off is documented. This part of the form is not completed routinely.

**Corrective Action:**

Ensure that identified corrective actions are implemented and signed off when completed.

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

##### **Criterion 1.2.3.9 (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:** 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 1.2.4: 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:**

The village manager and the nurse manager interviews confirm incidents and accidents are documented and staff are encouraged to complete the documentation when incidents happen. The incidents forms are reviewed and investigated by the nurse manager or registered nurse (RN) who monitor issues. If risks are identified these are also processed as hazards. Incidents are trended monthly and reported to the staff meetings and then onto quality meetings. Meeting minutes include discussions around incident and accidents.

Summerset by the Ranges incident data base is sighted. July to 7 October incidents are recorded against falls, pressure sore, chocking incident (on recommended diet), skin tears, bruising and wondering. Seventeen incident and accident reports were reviewed. All had immediate action noted and any follow up action required is completed. Incident and accidents are included in the care plan evaluations and linked to the short term care planning. Neurological observations are completed by the RN following a fall incident if a head injury is suspected.

Incidents and accidents are benchmarked across the organisation. Minutes of the village monthly quality improvement meetings reflect a discussion of incidents/accidents, actions taken and trends. There are clear links between the incident forms, the hazard register and the health and safety meetings.

Incident and accident audits are completed and care plan audits also link to the incident ensuring that whether or not required interventions are documented.

Interviews with the management confirm that they understand their obligation to report adverse events.

D19.3b: There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimize and debriefing.

##### **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:**

Summerset by the Ranges has comprehensive and well implemented human resource processes. Recruitment process is implemented and all required documentation is maintained in the staff file or digital copy is also available. The service has a comprehensive orientation program that provides new staff with relevant information for safe work practice. Three caregivers and two RNs interviewed describe the orientation process and confirmed that new staff are adequately orientated to the service. As part of the sample staff files, the nurse manager and three RNs files are reviewed and all had completed the orientation programme. Remaining three files are previous employee of the Summerset by the Ranges and they also had completed orientation document in their files, therefore, required corrective action from the previous audit has been addressed.

There is a clinical audit, training and compliance calendar 2014. The annual training program well exceeds eight hours annually. Interviews with three caregivers and two RNs identified that a high priority is given to training and that attendance is expected. All caregivers at Summerset by the Ranges have achieved level two of Career force national certificate in the support of the older person. There is a scheduled career force training. The DT and one of the RN are career force assessors and they support staff through obtaining the national qualification.

The registered nurses attend external training as well as the Summerset group provides internal training for registered and enrolled nurses. RNs are supported to maintain their professional competency. Staff training records are maintained. Annual performance appraisals are completed. Five out of seven staff files reviewed had completed performance appraisals and two of them are not due.

D17.7d: There are implemented competencies for registered nurses related to specialized procedure or treatment including (but not limited to); medication, pain, privacy, preventing elderly abuse and restraint.

##### **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 human resources planning document provides the rationale for staffing and skill mix.

Staffing level is adjusted according to the company policy and based on the number of residents and their acuity. Caregivers reported that staffing levels and the skill mix are appropriate and safe. All family member interviews confirmed that transition to the hospital level care is well managed and families felt that staffing level is sufficient. The village manager or the nurse manager on-call at all times, that at least one staff member on duty hold a current first aid qualification.

Previous audit finding around 24 hour RN cover and employment of nurse manager have been actioned. The service withdraw the application to provide rest home level care in the serviced apartments therefore the previous corrective action around 24 hour caregiver cover in the service apartments is not required.

Staffing is as follows (8 Hospital and 22 Rest home residents)

Village Manager – Monday to Friday -08.00-16.30

Monday-Friday - Nurse manager, 08.00- 16.30

AM

Monday-Sunday 1 x registered nurse 07.00-15.15

Monday-Sunday 2x caregivers 07.00-15.00; 1 x caregivers 07.00-12.00.

PM

Monday-Sunday 1 x registered nurse 15.00-23.15.

Monday-Sunday 2 x caregiver 14.15-23.00; 1 x caregiver 16.00-21.00.

Night

Monday-Sunday 1x registered nurse 23.00-07.15

Monday-Sunday 2x caregivers 23.00-07.00.

Laundry is completed by night staff

House keeper 8.30-15.00

Additional caregiver is rostered 08.00-13.00 by 20 October 2014.

##### **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:**

Admission procedures are carried out by registered nurses and the nurse manager. Assessments and care plans are developed by registered nurses and the nurse manager oversees this process. There is a registered nurse on duty at all times. Five resident files reviewed (two rest home and three hospital) showed that an assessment was completed within 24 hours of admission, and initial nursing care plan was also developed within this timeframe. The long term care plan (resident centered care plan) was completed within three weeks.

All five resident files reviewed identified that the general practitioner had seen the resident within two working days of admission with at least three monthly (and as needed) reviews. Three monthly medication reviews by a general practitioner are documented on all of 12 medication charts reviewed.

A range of assessment tools were completed in resident’s files on admission and thereafter at least six monthly. There are several falls screening, falls prevention and mobility assessments that are completed for residents who are identified as high falls risk.

There is evidence in all five files of continuity of service delivery including progress notes written at least daily and mostly each shift. Three caregivers and two RNs interviewed report a thorough handover and use of the communication book to ensure service delivery continuity.

Tracer Methodology: 1x Hospital

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

Tracer x2 Rest Home

*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 1.3.6: 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:** FA

**Evidence:**

Summerset by the Ranges provides services for residents requiring rest home and hospital level of care. The care being provided is consistent with the needs of residents. This is evidenced by discussions with the three caregivers, a diversional therapist, three families, the nurse manager and the village manager. Resident’s care plans are completed comprehensively. There is a short-term care plan that is used for acute or short-term changes in health status.

Five resident’s files reviewed (three hospital and two rest home). All care plans reviewed are well written, comprehensive and appropriate language for caregivers.

D18.3 and 4: Dressing supplies are available and a treatment room is stocked for use.

Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management.

Specialist continence advice is available as needed and this could be described.

Continence management in-services (August 2014) and wound management and pressure area care in-service (March 2014) have been provided.

There are nine residents with wounds. All wounds are skin tears except one resident with chronic wound which was developed pre-admission. There is an input obtained from the wound specialist nurse.

Short term care plans are evidenced in resident’s folders for wounds. Wounds are reviewed in the prescribed timeframes by registered nurses. Wound assessment and treatment plans are current and complete.

Two registered nurses interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse.

##### **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:** 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 1.3.7: 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:**

The activity programme is run by the diversional therapist (DT) who has been with Summerset over 3 years. She works Tuesday to Saturday for a total of 30 hours each week. The activities program includes 7 days a week and caregivers implements the program when the DT is not on duty.

A monthly programme is displayed around the facility. Resident’s activities participation is recorded and evaluated. Recreational progress notes are maintained. The resident/family/whanau as appropriate is involved in the development of the individualized activities plan. There is a range of activities offered, that reflects the resident needs.

The service has a van and outings are provided three times a week. Residents can be transported and this allows them to remain integrated in the community. The service has extensive links to the wider community, and the DT has connection with Horowhenua DT network group.

Resident interviews (two hospital and three rest home) confirmed that individual preferences are met and the programme is enjoyable.

Residents were observed to be busily involved in activities on the day of audit.

D16.5d Resident files reviewed (five) identified that the individual activity plan is reviewed when at care plan review.

##### **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:**

Care plans are evaluated by RNs. Five files reviewed showed that six monthly evaluations are comprehensive and resident focused. There is evidence that evaluations are conducted when health status changes. Short term care plans are well utilized and evaluated on a regular basis. Short term care plans are transferred to the long term care plans if condition becomes chronic. There is evidence of allied health professional’s involvement where progress is less than expected. Review of medical notes shows that GPs are contacted in a timely manner when progress is less than expected or when health status changes and there are concerns. Family and resident interview confirms timely referral to the GP or specialist services.

The GP was not available for an interview on both days of audit.

D16.4a: Care plans are evaluated six monthly more frequently when clinically indicated.

##### **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:**

There are policies and protocols are in place to manage the safe and appropriate prescribing, dispensing, administration, review, storage and disposal of medicines in order to comply with legislation, regulations and guidelines. There is a contract with the pharmacy. Medication is checked on arrival at the facility. RNs or the nurse manager initial the blister pack to verify that checking against the medication chart has occurred when medication are received from pharmacy. All medications are kept in a locked trolley and cupboard in the treatment room. Medication fridge temperature is recorded daily. Resident medication charts are identified with photographs. When identification of allergies occurs, this is documented on the medication charts. Medication incidents are to be investigated as per the medication error management procedure. The service includes medication errors in their accident and incident reporting. There are no residents self-medicating.

The service withdraw the application to provide rest home level care in the serviced apartments therefore the previous corrective actions around medication management system are not required.

The audit identified an improvement required around medication management system.

##### **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:**

12 individual resident’s medication charts (four rest home and eight hospital) are reviewed. All medication charts evidenced three monthly medical review signed by a GP on medication charts.

There are 10 medication competent caregivers however since beginning of hospital level care provision; medications are administered by the RNs. Three caregivers interviewed stated that they maintained their medication competency and administer medications if requested by the RNs.

There is a locked safe and controlled drug register for the safe keeping and administration of controlled drugs. A weekly stock take is undertaken by RNs. Controlled drugs are managed appropriately and safely. There are no residents requiring regular controlled drugs. There is one resident requiring PRN controlled drug which has not been used yet.

Two registered nurses and three medicine competent caregivers interviewed could explain their responsibilities in regard to each stage of medicine management

Medication management training is provided to staff in July 2014, and insulin administration training in June 2014.

**Finding:**

(i)A resident was admitted from the public hospital and current medications were changed and this was identified in the discharge report. This change was faxed to the contracted pharmacy and medication was administered against the original medication script provided by the hospital. Medication administered on the day of audit is correct against the hospital medication script however, signing sheets do not match with the current script and the medication chart updated by the GP has two copies (one being the original chart) and these two charts also do not match including start date of medications. (ii) Two out of 12 medication signing sheets have medication signing gaps. (iii) On one chart, two medications were stopped (crossed over) by the GP but the stop date was not documented and also not signed by the GP.

**Corrective Action:**

Ensure that medications are reconciled when a resident re-admitted to the facility. Ensure that medication is signed as administered. Ensure that discontinued medications are dated and signed by the GP.

**Timeframe (days):** 90 *(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:** 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 1.3.12.6 (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 is prepared on site and food service is contracted.. The kitchen is well maintained and clean. A weekly rolling menu is implemented and, required changes to summer and winter menu is approved by the contracted company dietitian. A copy of residents nutritional profiles are maintained in the kitchen. Resident’s food satisfactions are followed immediately. This is confirmed by the chef/manager, two RNs, three caregivers and five residents. The chef/manager serves the meals directly from the kitchen and listens to concerns and suggests possible solutions.

All staff handling food has food handling certificates. Food temperatures are monitored when it is cooked and before serving meals. Frozen food supplies are also temperature monitored on arrival.

Residents are given a choice such as alternate meat dishes and vegetarian. There is evidence of modified diets being provided such as diabetic menu and further nutritional supplements. The kitchen has a fridge freezer and temperatures are monitored daily, food was covered and labeled.

The facility has lipped plates, feeding cups and built up cutlery available for residents that have difficulty feeding. Staff was observed assisting some residents at meal time.

Resident’s individual needs are identified, documented and reviewed on a regular basis. Five residents (three rest home and two hospital) interviews confirmed that individual preferences are catered for and they stated they enjoy their meals.

Regular monitoring of resident’s weight and nutritional needs occur. Resident’s dietary profile is completed on admission and is evaluated regularly. Residents care plans include interventions around dietary needs. Special diets are catered for.

Resident satisfaction surveys include food services. Residents rated food services 4.2 out of 5 in 2014 survey. Food is discussed at residents meetings and follow up actions are completed.

##### **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:**

There is a current building warrant of fitness that expires on July 2015. Maintenance plan is implemented. The property manager oversees maintenance across the facility, apartments and village. Required corrective action around safe outdoor access has been addressed. The service does not currently have any residents who require a tilting shower chair. This is on order and the service is waiting for its arrival.

##### **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.)*

##### **Criterion 1.4.2.4 (HDS(C)S.2008:1.4.2.4)**

The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of 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 1.4.2.6 (HDS(C)S.2008:1.4.2.6)**

Consumers are provided with safe and accessible external areas that meet their needs.

**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:** FA

**Evidence:**

There are policies around restraint, enablers and the management of challenging behaviors which meet requirements of HDSS 2008. The service does not currently use restraint or enablers. Policy dictates that enablers should be voluntary and the least restrictive option possible.

Staff received training around restraint minimization and the management in challenging behavior which is completed in May 2014. All staff hold a national qualification in care of elderly, and career force level 2 training includes restraint minimization which was also held in May 2014. Three caregivers and two RNs interviewed are knowledgeable around restraint minimization and enablers.

##### **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:** 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 8134.3:2008: 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:**

The infection control coordinator (registered nurse) is responsible for coordinating and providing education and training for staff. Infection control coordinator has a graduate certificate in infection control and prevention. Infection control data is collated monthly and trends and analysis of infections are discussed at the quality improvement/staff meetings. Action is taken to reduce the infection rates according to surveillance results and any issues of urgency are dealt with in a timely manner. The results from infection control data analysis are benchmarked against other Summerset facilities.

Document review showed that the service had an infectious outbreak (norovirus) on 26 July 2014 and notification to the local DHB and public health authorities occurred. Quality improvement/staff meetings include discussions around the management of the outbreak and learning’s to change practice.

##### **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.)*