# Summerset Care Limited - Summerset in the Vines

## Introduction

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

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Summerset Care Limited

**Premises audited:** Summerset in the Vines

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 28 October 2014 End date: 29 October 2014

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 39

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

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

## General overview of the audit

Summerset in the Vines is part of the Summerset group. The facility is certified to provide hospital (geriatric and medical) and rest home level care for up to 41 residents in the care centre. On the day of the audit there were 23 hospital residents and 16 rest home residents in the care centre. Summerset in the Vine’s village manager and nurse manager are well qualified for their roles.

Five of the nine shortfalls from the certification audit have been addressed. These are around neuro observations following potential head injuries, documentation and ongoing documentation of clinical care, interventions in care plans and evaluation.

The shortfalls around assessments, documentation of interventions including wound documentation, medication administration and staff medication competency assessments continue to require improvement.

This audit identified additional improvements required around incident reporting, short term care plan evaluation and medication management.

## Consumer rights

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Standards applicable to this service fully attained. |

Summerset in the Vines provides care in a way that focuses on the individual resident. Family are informed when resident health status changes. There is a documented process for making complaints and residents, family and staff interviewed are able to discuss the complaints process. Complaints are recorded on an electronic register that includes the complaint, action taken and sign-off.

## Organisational management

|  |  |  |
| --- | --- | --- |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of low risk. |

Summerset in the Vines is implementing a quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to a number of meetings including monthly quality meetings. 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 is one improvement required around incident reporting.

## Continuum of service delivery

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

Assessments, care plans and evaluations are completed by the registered nurses. Risk assessment tools and monitoring forms are available. Improvement in relation to behaviour assessments and ongoing pain assessment are required. Care plans are individualised and evaluated six monthly. The resident/family/whanau confirms they are involved in the care plan process and review. Long term care plans are in place. Interventions in the plans, and wound management documentation are not consistently updated. Short term care plans are used for short term health issues. Evaluation of these plans is an area for improvement. The recreational therapist provides an integrated seven day week programme open to all residents to attend. The activities programme is varied, interesting and involves the families, volunteers, community visitors, entertainment and outings. There are medication management policies that direct staff in terms of their responsibilities in each stage of medication management. Medication profiles are legible and up to date. There are improvements required around medication administration, competence of residents self-medicating and staff medication competencies. Meals are prepared on-site by a catering contractor. Individual and special dietary needs are catered for. Residents interviewed responded favourably to the food that was provided.

## Safe and appropriate environment

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

There is a current warrant of fitness, there is reactive and planned maintenance. Hot water temperatures are monitored monthly with corrective actions taken as required. Electrical, mechanical and calibration checks are maintained for all equipment

## Restraint minimisation and safe practice

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

The restraint policy and procedure has a clear definition of restraint and enablers and includes a philosophy of restraint minimisation. There are seven residents requiring restraint and one using an enabler. Staff receive education related to restraint minimisation during orientation and as part of the education programme. Documentation is in place for assessment, approval, monitoring, review and evaluation of restraint.

## Infection prevention and control

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

There is an infection control policy that includes surveillance activities. Infections are reported and collated monthly. Infections and internal audit outcomes are discussed as part of the infection control meetings. Information is available to staff. The surveillance programme is appropriate to the size and complexity of the facility.

## Summary of attainment

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 15 | 0 | 2 | 2 | 0 | 0 |
| **Criteria** | 0 | 39 | 0 | 5 | 1 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | 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), an electronic database, where action taken and close out date is recorded. Complaints are discussed at the monthly quality meeting. Complaints forms are visible around the facility. Interview with the village manager and review of the electronic process indicates a total of five closed and two open complaints from care centre residents received across the 2014 year. There is evidence of investigation, resulting staff performance management (when appropriate), and follow up with complainants.  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 one hospital) and relatives (one rest home and one 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. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | 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. Family interviewed (two) and progress notes confirm family are notified (link 1.2.4). Interview with four caregivers (who work with hospital and rest home residents) and two registered nurses (RN’s) inform family are kept informed. The service has policies and procedures available guiding access to DHB interpreter services. Residents (and family/whānau), are provided with this information in resident information packs on admission.  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 (one rest home and one hospital) stated 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. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Summerset in the Vines provides care for up to 41residents in the care centre across two service levels (rest home and hospital). On the day of audit there were 16 rest home residents and 23 hospital residents. One of the rest home residents was respite. The care centre rooms have previously been assessed as suitable for either rest home or hospital level care. Summerset in the Vines is certified to provide medical services under the hospital component of its certificate. At the time of the audit, there were no residents under this category of care.  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 Vines. 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. There is a monthly quality meeting at Summerset in the Vines that includes discussion about clinical indicators (e.g. incident trends, infection rates).  The service is managed by a village manager who is a registered nurse with a current practising certificate. She has been in post since June 2013. She has previous experience at another Summerset facility. She is supported by a nurse manger (registered nurse) who has been in post for approximately five years. The nurse manager was on leave at the time of audit. 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. |
| 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. | FA | Summerset in the Vines 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 Vines. The calendar schedules the training and audit (etal) requirements for the month and the village manager reports on completion of requirements. There is a monthly quality meeting that includes discussion about clinical indicators (e.g. incident trends, infection rates) and all aspects of the quality programme. Summerset in the Vines infection control and health & safety committees both meet three monthly. A report is provided to the quality meeting from these committee meetings (sighted). Information is then discussed at the weekly care staff/clinical update meetings and the monthly registered nurse meetings (verified via interview with four caregivers and two registered nurses).  Resident/family meetings occur three monthly and a meeting facilitated by Aged Concern occurs quarterly. Meetings are minuted.  Summerset in the Vines 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, noting at the time of audit a small number of corrective action plans are still in process.  D19.3: There is a H&S and risk management programme in place including policies to guide practice. The committee monitors staff accidents and incidents as part of the three monthly meeting (interview with H&S rep).  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. |
| Standard 1.2.4: Adverse Event Reporting  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. | PA Low | D19.3c: The service collects incident and accident data and reports aggregated figures monthly to the integrated meeting. 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. Ten incident forms were reviewed in detail and a further 31 scanned for completeness, there was inconsistency noted in completion of the forms.  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. Discussions with service management, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications.  The finding from the previous certification audit relating to completion of neuro observations following head injury has been addressed. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | There are human resources policies to support recruitment practices. A list of practising certificates is maintained. Six staff files were reviewed (two registered nurses – one was the infection control coordinator, three care givers – one was a health and safety rep, recreational officer) and all had relevant documentation relating to employment. A performance appraisal was not due in one file, current in two, and scheduled to occur in the remaining three. There is a tracking schedule in place to monitor the appraisal process. The three staff whose appraisals are due have been given the relevant documentation and appointments are being scheduled. Based on the evidence this aspect of the standard is considered to have been met. There is evidence on staff files of appropriate performance management.  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 (four caregivers, two registered nurses) 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 four caregivers (who work across care centre).  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 scanned into ‘sway’ (link 1.3.12). 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. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | 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.  There is a registered nurse on duty 24 hours per day.  There is dedicated housekeeping and laundry staff, and 41 hours/week of rostered recreational time. At the time of audit recruitment of a second recreational therapist is underway, once appointed the intent is to have a seven day programme fully implemented.  Physiotherapy services are contracted.  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. The service is due to move to a four on two off roster. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within required timeframes into the resident’s individual record. An initial care plan is also developed in this time. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access by being held in a locked staff area. Care plans and notes are legible. All resident records contain the name of resident and the person completing. D7.1 Entries are legible, dated and signed by the relevant caregiver or registered nurse including designation. Policies contain service name. Care plans and progress notes are legible. The finding from the certification audit around staff signatures, dates and designations has now been addressed. |
| 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 Moderate | The service medication management system follows recognised standards and guidelines for safe medicine management practice in accordance with the guideline: Safe Management of Medicines, A Guide for Managers of Old People’s Homes and Residential Care Facilities and the Ministry of Health, Medicines Care Guide for Residential Aged Care 2011. The facility uses monthly supplied Douglas Medico medication packs. Medications are checked on arrival at the facility. All medications are kept in the locked treatment room. The medication fridge temperature is recorded weekly.  Twelve medication charts were reviewed and all but one are identified with photographs and were current. Ten of 12 medication charts sampled have administration signing sheet errors and two medication charts had a GP review signed outside the three month period. These are areas requiring improvement. There is no evidence of transcribing. Controlled drugs are stored in a locked safe and are checked by two staff each time they are administered, only one staff member signs the administration sheet and this is an area for improvement. Two staff complete weekly controlled drug stocktakes.  Medication is administered primarily by registered nurses, and they complete an annual competency. Caregivers check controlled drugs and there are shifts where the caregiver checking medication has not completed a competency and this is an area for improvement.  Medication audits occur annually. The service has in place policies and procedures for ensuring all medicine related recording and documentation meets acceptable good practice standards. Medication and any changes are discussed with the resident or family/whanau where appropriate and documented in the progress notes. This was verified in resident and family interviews.  All medication in the fridges, drug trolleys and cupboard were sighted.  D16.5.e.i.2; Two of 12 medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed.  There is a self-medicating resident’s policy available to guide staff practice if required. There is one resident self-administering one medicine. Competence is reviewed by the GP at the three monthly reviews. There is no evidence this occurred at the last review.  The findings from the certification audit relating to signing sheets and three monthly reviews being recorded on medication charts and competency assessment are recurring. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | There is a large kitchen and all food is cooked on site by external contractors. There is a comprehensive kitchen manual in place. The cook (interviewed) reports to the area manage. There are two qualified staff across the seven day period. They are supported by a morning and afternoon catering assistant. The kitchen supplies food for the newly opened café on site. There is an eight week menu seasonal menu is in place. The company dietitian sends out the menu when due for review for site input into the menu plan. The kitchen receives a dietary profile for each resident with dietary requirements, special diets, food allergies, likes and dislikes. Alternatives are offered. The kitchen is notified of any dietary changes for the residents. Special diets are catered for. There are specialised cups, plates and utensils to promote resident independence at meal times. End cooked food temperatures and serving temperatures are recorded on each meal. The kitchen is well equipped. The fridge and freezer have visual temperatures which are recorded daily. The facility fridge temperatures are monitored (records sighted). The pantry is well stocked and holds enough food for five days. All dry goods are sealed and dated. All perishable goods in the fridges are date labelled. Daily, weekly and monthly cleaning schedules are maintained. Chemicals are stored safely within the service. The chemical provider completes monthly service checks on the dishwasher and chemical use. Feedback on the service and meals is by direct verbal feedback and customer services.  D19.2: Staff working in the kitchen have food handling certificates and receive on-going training. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | PA Low | The initial support plan is developed with information from the initial assessment. Clinical risk assessments including continence, safe handling, falls risk, pressure area risk, culture assessment, pain assessment and wound assessments are completed as applicable following admission and reviewed at least six monthly in two of five resident files sampled (the remaining three residents reviewed had not been in the service longer than six months). Risk assessment tools are available to assess level of risk and required support for residents. Continuing needs/risk assessments are carried out by registered nurses. Needs outcomes and goals of residents are identified and link to care plans.  Five files sampled (two rest home and three hospital) contain assessments which are current. There are examples where assessments are not evident such as behaviour and pain, and this is an area for improvement recurring from the certification audit. Residents and relatives interviewed report having been involved in the assessment process. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Five care plans were reviewed for this audit, two rest home and three hospital. Assessment tools relevant to a specific area of the support plan are completed (link 1.3.4).  Residents' files include; daily progress notes, recordings, relative contact, care planning consultation record, long term care plan, risk assessment tools, short term care plans/wounds, enabler/restraint documentation, care plan evaluations (MDT review), GP initial assessment and visits, lab results, allied health reports, activities, consents and advance directives, letters, referrals and archived notes. Care plans demonstrate service integration and input from allied health including GPs, district health board services, in files sampled. Notes are maintained by the general practitioner and significant events, communication with families and notes (as required) are maintained by registered nurses. D16.3k: Short term care plans are in use for changes in health status (link 1.3.8). D16.3f Five files sampled (two rest home and three hospital) reviewed identified that family were involved.  The finding from the certification audit relating to interventions in the care plan is considered to be met based on the files reviewed. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate | Summerset in the Vines provides services for residents requiring rest home and hospital level of care. Overall, the care plans are completed comprehensively. Residents interviewed (two rest home and one hospital) state their needs are being met. Relatives interviewed (one rest home and one hospital) state their relatives receive care within a timely manner and they are kept informed of any health changes, GP visits and care plan reviews. When a resident's condition alters, the registered nurses initiate a review and if required, GP or specialist consultation.  D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use. Continence products are available and where required, 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 have been provided.  There are ten residents with wounds; one resident was in hospital at the time of audit. In the documentation reviewed there are gaps in recording and paperwork used for wound management. This is a recurring area requiring improvement.  A resident’s mood or behaviour is considered as part of the long term care planning process. In one file, behaviours that challenge were not recorded in the long term care plan. Pain assessments are completed on admission for all residents with identified and on regular or prn pain relief. Pain assessments include non pharmalogical strategies. Pain assessments are reviewed every six months and initiated for new or exacerbation of chronic pain (link 1.3.4). The effectiveness of pain relief is documented in the progress notes. Falls risk assessments are completed for residents on admission and reviewed six monthly or earlier for resident falls. Falls prevention strategies are identified, documented and implemented. For residents who falls frequently a repetitive falls screening tool is completed. A referral is made to the physiotherapist. There is an improvement required around recording physiotherapy input in progress notes. Resident’s weights are recorded on admission and monthly thereafter on the monthly weight chart. Interventions for weight loss are included in the long term care plan, in one file the prescribed weekly weighs, and could not be evidenced. The dietitian can be accessed through the external kitchen provider service. |
| Standard 1.3.7: Planned Activities  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. | FA | The recreational therapist has been with the service for two months, and this is her first activities role. She currently works 24 hours/week across four days. At the time of audit a second therapist is due to be appointed which will provide 41 hours/week across seven days. The activities programme is developed by the recreational therapist and the monthly plan is displayed throughout the facility. The plan is easy to read and colourful, it can be printed in large type to assist those residents with who are visually impaired. Activities are planned that are appropriate to the functional capabilities of residents. Residents are able to participate in indoor bowls, and an exercise programme. One on one time is spent with hospital level residents or those who choose not to participate in the groups. Volunteers provide music and piano entertainment. Residents go out to community events such as concerts. Special events, festive occasions and birthdays are celebrated. There are weekly van outings and resident provide feedback and suggestions for the outings.  D16.5d The activity assessment is completed in consultation with the family on admission. The activity care plan is developed within three weeks of admission and reviewed at the same time as the care plan. Monthly progress notes are written. Five files sampled (two rest home and three hospital) have a documented activities plan. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | There is evidence of resident and family (where appropriate) involvement in the review of support plans. As only two of five care plans reviewed were due an evaluation, the sample was widened. A total of six files were reviewed of residents that had been in the service over six months. In all instances there was a documented care plan evaluation and the finding from the certification audit is considered to be met. D16.4a Six care plans sampled have a documented six monthly multidisciplinary care plan evaluation or earlier if there are changes to health status.  Short term care plans used to focus on acute and short-term issues – in one (of five) files reviewed the progress notes record a short term care plan (STCP) was developed (in June), however this was not in the resident file. As there is evidence of consistent use of STCP’s in the remaining files reviewed, this occurrence is not considered a trend and the criterion is considered to be met. STCP’s are used when a change in health status is noted such as infections.  ARC D16.3c: All initial care plans were evaluated by the registered nurses within three weeks of admission. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | Planned and reactive maintenance systems are in place and maintenance requests are generated through the on-line system using the Sway programme. There is a current building warrant of fitness expiring 25 February 2015. Hot water temperatures are recorded monthly and are consistently reading 42-45 degrees Celsius. A visual Inspection of the facility provides evidence of safe storage of medical equipment. ARC D15.3: The four caregivers and two registered nurses (interviewed) state they have all the equipment required to provide the care documented in the care plans. The following equipment is available: electric beds, ultra-low beds, sensor mats, shower chairs, hoists, mobility aids and wheel-on weigh scales. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Infection monitoring is the responsibility of the infection control coordinator (registered nurse). 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 Vines 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 (minutes viewed). 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. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | 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 nurse manager (registered nurse) is the restraint co-ordinator with a job description that defines the role and responsibilities. The nurse manager was on leave at the time of audit and the village manager (interviewed) discussed the process. The policy identifies that restraint is used as a last resort. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies such as behaviour monitoring, sensor mats and ultra-low beds have been ineffective. The service currently has seven residents on restraint (bed rails and lap belts). There is provision for emergency restraint and the nurse manager is reportedly contacted for prior approval for restraint to be implemented. There is a restraint committee who meet three monthly and report to the quality committee. Enablers are voluntary and the least restrictive option. The enabler register shows one resident using bed rails as an enabler. |

# Specific results for criterion where corrective actions are required

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

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

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 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. | PA Low | Incident forms are completed by staff following an event. The resident is reviewed by the registered nurse at the time of event and the relevant section of the form completed. The form is forwarded to the nurse manager for final sign off, following which the form is filed, scanned and reported through the ‘sway’ system. Interview with the village manager confirmed an awareness of resident incidents and resulting outcomes. Review of 41 incident forms highlighted that eight forms did not document that family had been notified following an event, and six forms did not have nurse manager (or equivalent) sign off. It is noted family and residents interviewed, and the family communication sheet in the residents file evidencing family are informed following a change in health status. | The incident forms reviewed were not consistently completed as prescribed, including indicating if family had been notified and/or final sign off by the nurse manager (or equivalent). | Incident forms are completed as prescribed.  90 days |
| 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 | All medications are kept in a locked trolley in the treatment room. All eye drops in use (sighted) are dated on opening. The medication fridge temperature is recorded daily. The prescribing of regular and prn medications meets legislative requirements. Twelve medication charts were reviewed and all but one are identified with photographs and were current. Ten of 12 medication charts sampled have administration signing sheets errors and two medication charts had a GP medication review signed outside the three month period. There is no evidence of transcribing. Controlled drugs are stored in a locked safe and are checked by two staff each time they are administered; only one staff member signs the administration sheet. Two staff complete weekly controlled drug stocktakes. | The following was noted during review of the medication system: one medication chart did not have a current resident photograph, ten of the twelve charts had gaps on the administration signing sheet, and there is only one signature on the signing sheet in respect of controlled drugs (four residents reviewed). Two medication charts recorded a review period outside of the three month timeframe. | Ensure medication management meets accepted standards.  30 days |
| Criterion 1.3.12.3  Service providers responsible for medicine management are competent to perform the function for each stage they manage. | PA Low | Medication is administered primarily by registered nurses, who complete an annual competency. Completed competencies are scanned into ‘sway’; a random selection of RN’s showed a current medication competency. There is one registered nurse on each shift. Medication is occasionally administered by caregivers in the rest home, the senior caregivers interviewed (two) reported having a current medication competency. Caregivers also check controlled drugs. Review of the roster 20-26 October, there are three shifts – one afternoon and two night duty – where the caregiver/s checking medication do not have a current medication competency. | There are shifts across a week period where the caregiver/s checking medication have not completed the prescribed annual competency. | Ensure staff involved in medication management complete the relevant competency.  30 days |
| Criterion 1.3.12.5  The facilitation of safe self-administration of medicines by consumers where appropriate. | PA Low | There is a self-medicating resident’s policy available to guide staff practice if required. There is a resident self-administering one medicine that has a locked cupboard in her room. She could explain how the medicine is managed and safety of the key to the cupboard. Competence is reviewed by the GP at the three monthly reviews; however this has not been recorded in the progress notes at the most recent review. There are no other residents self-medicating at the time of audit. | One resident is self-medicating one medicine. Review of the resident’s competence is managed as part of the three monthly GP review, this was not recorded during the last review. | Ensure competency of residents who self-medicate is recorded in the resident file and reviewed at appropriate intervals.  60 days |
| Criterion 1.3.4.2  The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning. | PA Low | Resident information is gathered during admission using various assessment tools, these are reviewed and updated six monthly. An initial support plan is completed within 24 hours. This information is used to assist in developing the care plan. The long term care plan includes goals and interventions. Continuing needs/risk assessments are carried out by registered nurses six monthly or more frequently as needed. There is a resident recently admitted to the service (tracer) who is exhibiting behaviours that challenge and a behaviour assessment has not been completed. In addition the resident has on-going pain reported in progress notes and while a pain assessment chart has been commenced this is incomplete. A rest home resident’s long term care plan (tracer) reports daily pain assessment be completed, these on-going assessments were not evident. | In the five files reviewed a resident exhibiting behaviours (hospital) that challenge does not have a behaviour assessment and in two files (both rest home) pain assessment recording is incomplete. | Complete appropriate risk assessments based on resident need and as prescribed in care plans.  60 days |
| 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 Moderate | Residents interviewed (two rest home and one hospital) state their needs are being met. Relatives interviewed (one rest home and one hospital) state their relatives receive care within a timely manner and they are kept informed of any health changes, GP visits and care plan reviews. When a resident's condition alters, the registered nurses initiate a review and if required, GP or specialist consultation.  Dressing supplies are available and a treatment room is stocked for use. There are ten residents with wounds; one resident was in hospital at the time of audit. There are various documents making up the wound management system such as ‘1st assessment and weekly assessment sheet’, ‘long (or short) term wound care support plan’, and ‘wound assessment and review tool’. In the paperwork reviewed: the size of the wound is inconsistently recorded on the weekly assessment sheet, there were multiple wounds recorded on one plan and one grade 3 wound did not have a wound assessment and review tool on file. There are also instances where a short term care plan is used to manage minor wounds.  A resident’s mood or behaviour is considered under emotional safety in the long term care plan. A resident exhibiting behaviours that challenge, did not have these behaviours (or alternative strategies) recorded in the long term care plan. A referral is made to the physiotherapist (PT) when required. In one file the GP requested PT input, and while the registered nurse informed the consultation had occurred there is no evidence of physiotherapy involvement in the residents file. Resident’s weights are recorded on admission and recorded monthly thereafter. In one file reviewed a resident who had lost 6.4kg across one month was required to have weekly weighs. In addition a food monitoring chart was in place. The weekly weighs were not evident and the food monitoring chart incomplete. | The care plan does not reflect current needs for one resident with behaviours that challenge and the interventions in the long term care plan (weekly weighs) could not be located. In addition the food monitoring documentation was incomplete. There is no evidence in the relevant resident files of a physiotherapist assessment. Review of the wound management system shows inconsistency in documentation and recording of wound progress. | Ensure that interventions are documented to reflect current needs of residents, and that interventions are implemented (and recorded). Ensure allied health involvement is recorded in the residents file and documentation of wound management is consistent and complete.  60 days |

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

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

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

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

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End of the report.