

# Summerset Care Limited - Summerset At Aotea

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## 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](#).

The specifics of this audit included:

**Legal entity:** Summerset Care Limited

**Premises audited:** Summerset at Aotea

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 8 January 2015 End date: 9 January 2015

**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:** 18

# Executive summary of the audit

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## Introduction

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

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

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

## Key to the indicators

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

<b>Indicator</b>	<b>Description</b>	<b>Definition</b>
	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 at Aotea provides care for up to 46 residents at rest home level care in a serviced apartment complex. On the day of audit there were 18 residents receiving rest home level care.

The service is managed by a non-clinical Village Manager who has been in the current role since June 2014. She has been with Summerset over seven years in an administrative role. She is supported by the Clinical Nurse Leader who is a registered nurse with five years of experience in aged care. She has been in the role for three months. Support is also provided by the Clinical Quality Manager and the Clinical Education Manager who are based at the head office.

Family and residents interviewed all spoke positively about the care and support provided. Shortfalls from the previous audit around, dating of continence assessments, progress notes, evaluations, fridge temperatures and meeting minutes have been addressed. There is still an improvement required around timeliness of initial general practitioner reviews. This audit identified further improvements required around timeliness of service provision around three monthly medication reviews and follow ups following discharge from specialist services.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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There is an open disclosure policy which describes ways that information is provided to residents and families. Regular contact is maintained with family including if an incident or care/ health issues arises. Document review confirms that open disclosure principles are implemented. Complaints processes are known by the staff, residents and families and the complaint register is up to date.

## 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.		Standards applicable to this service fully attained.
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The service operates an established quality and risk management system that is supported by the Summerset head office. An annual resident and/or relative satisfaction survey is completed. There is an internal audit schedule that continues to be implemented. Adverse event reporting occurs and staff communicate events to relatives where appropriate. Key quality indicators continue to be benchmarked with other Summerset facilities. Annual review of the quality and risk management system has been completed and the new quality and risk management plan has been developed. There are established human resources policies and procedures in place. New staff are provided with a comprehensive orientation programme. There is an in-service training programme covering relevant aspects of care and support. The organisational staffing policy aligns with contractual requirements and includes skill mixes. Staffing levels are appropriate for the level of service provided. Summerset Aotea has addressed the corrective action required with documentation of meeting minutes from the previous audit.

## 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 low risk.
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Assessments, care plans and evaluations have been completed by the Clinical Nurse Leader. Risk assessment tools and monitoring forms are available and implemented. Care plans reviewed were individualised. Short term care plans have been utilised for changes in health status. Care plans have been evaluated six monthly or more frequently when clinically indicated. Activities are planned to meet the needs of the resident. Sufficient activities and outings have been provided. An appropriate medication management system is in place. Required corrective actions from the previous audit around continence assessments, progress notes and evaluations have been addressed.

Food is prepared on site by the village café. Residents with special dietary needs have these needs reviewed as part of the six monthly care planning review process. Residents interviewed confirmed satisfaction with food services.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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There is a current Building Warrant of Fitness that expires on 08 October 2015.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The Clinical Nurse Leader is the restraint co-ordinator with a job description that defines the role and responsibilities. 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 minimisation and the management of challenging behaviour. Summerset at Aotea has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint or enabler use should this be required.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection control programme is appropriate for the size and complexity of the service. Infection control data is collated monthly. Results of data analysis are communicated to staff. Action is taken to reduce the infection rates according to surveillance results and any issues of urgency are dealt with in a timely manner. Results from infection control data analysis is benchmarked against other Summerset facilities.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	15	0	1	0	0	0
Criteria	0	38	0	1	0	0	0

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld.	FA	<p>Complaints policy describes the management of the complaints process. There is a current complaints register which is kept in the Summerset intranet and monitored by the Summerset head office. There was only one complaint for the care centre recorded in the register from January 2014 to date. The complaint reviewed noted acknowledgement, investigation, time lines, corrective action and resolution. Results were fed back to complainants.</p> <p>Discussions with five residents and two family members confirmed that any issues are addressed and they are well informed about the complaint processes. Review of the staff and quality improvement meeting minutes included discussions about the complaint. Five residents and two family members inform an understanding of the complaints process. Two caregivers and the Clinical Nurse Leader interviewed were able to describe the process around reporting complaints.</p>
Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to	FA	<p>There is an open disclosure policy which describes ways that information is provided to residents and families. Admission pack includes a comprehensive range of information regarding the scope of the service provided to the resident and their</p>

<p>effective communication.</p>		<p>family/whānau and this information was discussed with them on entry to the service. Regular contact was maintained with the families including if an incident or care/ health issues arise.</p> <p>Discussions with two caregivers identified their knowledge around open disclosure. Eight incident/accident forms were reviewed, and eight of those identified that the next of kin were contacted and in two occasions the resident requested staff not to contact family members.</p> <p>Annual resident and relative surveys were also completed. Residents and relatives 2014 survey showed 97% satisfaction with the service.</p> <p>Interview with two caregivers, the Clinical Nurse Leader and the Village Manager confirmed that families were kept informed.</p> <p>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.</p> <p>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.</p> <p>D16.4b Two family members interviewed stated that they were well informed and involved when needed in residents care.</p> <p>D11.3 The information pack is available in large print and this can be read to the residents.</p>
<p><b>Standard 1.2.1: Governance</b></p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Summerset at Aotea provides care for up to 46 residents at rest home level care in a serviced apartment complex. On the day of audit there were 18 residents receiving rest home level care.</p> <p>The service is managed by a non –clinical Village Manager who has been in her current role since June 2014. She has been with Summerset over seven years in an administrative role. She is supported by the Clinical Nurse Leader who is a registered nurse with five years of experience in aged care. She has been in the role for three months. Support is also provided by the Clinical Quality Manager and the Clinical Education Manager who are based at the head office.</p> <p>Summerset provides a comprehensive orientation and training/support programme for their managers. Village Managers have monthly teleconference meetings with the</p>

		<p>Summerset Operations General Manager and twice yearly village manager's meetings in the head office. The Clinical Nurse Leader and the Village Manager have completed the Summerset orientation program.</p> <p>ARC, D17.3di (rest home): The manager has maintained at least eight hours annually of professional development activities related to managing a rest home.</p> <p>There is an overall Summerset business plan and risk management plan. Quality review of 2014 quality and risk management plan was completed in December 2014 and this review was used to develop quality goals for 2015.</p> <p>Summerset has comprehensive quality and risk management systems implemented across its facilities. Across Summerset, benchmarking groups are established for facilities with similar service levels. Benchmarking of the key clinical quality indicators and incident data are also carried out.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>Summerset at Aotea has an established quality and risk management system. The internal auditing programme 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 programme reflect the service's on-going progress around quality improvement.</p> <p>Quality data continues to be reported through the monthly quality improvement and staff meetings. The key components of the programme include audits, surveys, infection control and prevention, incidents, complaints, training, restraint minimization and health and safety.</p> <p>Incidents and accidents are reported, analysed and recorded on a monthly summary sheet. An infection rate monthly summary has been completed. Hazards are reported and the hazard register was reviewed annually. All quality data has been entered in to the Summerset database management system "Sway- the Summerset Way" which collects all data from each Summerset facility and generates site specific analysis reports.</p> <p>Benchmarking with other summerset facilities occur and benchmarking data is obtained through Sway. This will be an addition to the current internal benchmarking program.</p> <p>There is a 2014 clinical audit, training and compliance calendar which were</p>

		<p>implemented.</p> <p>Consumer satisfaction survey was completed in 2014 and shows 97% satisfaction.</p> <p>There is a monthly teleconference with Summerset head office that includes discussions around quality improvements and new initiatives across the Summerset facilities.</p> <p>There is an organisational clinical group that meets and reviews policies and procedures and best practice. There is a document control policy that includes clear guidelines for review and amended policies.</p> <p>Responsibilities and timeliness of required corrective actions were documented and signed off when it was completed. This is an improvement since the previous audit.</p> <p>D19.3: There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management.</p> <p>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.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>D19.3b: There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimize as well as debriefing.</p> <p>Eight incident and accident reports (Oct/Nov 14) reviewed showed that all had immediate action noted and any follow up action required was completed. Incident and accidents were included in the care plan evaluations and linked to the short term care planning. Progress notes included incidents and accidents and monitoring requirements.</p> <p>The hazard register was up to date and hazards were reported through incident and accident reporting. Incidents are trended monthly and reported to the staff meetings, health and safety meetings and then onto quality improvement meetings. Meeting minutes include discussions around incident and accidents.</p> <p>Discussion with the Village Manager and the Clinical Nurse Leader indicated that management are aware of and are able to describe their statutory requirements in relation to essential notification. Document review showed a notification of an infectious outbreak in 2014.</p> <p>Incident and accident audits are completed. November 2014 audit identified 93%</p>

		compliance and the required corrective actions were completed by the Clinical Nurse Leader.
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	<p>There is 26 staff employed by Summerset at Aotea. The Clinical Nurse Leader works full time and there is also another RN available on a casual basis.</p> <p>The staff are required to undergo an orientation process and then to take part in the ongoing education programme. Six staff files reviewed showed that the employment process includes interview notes, validation of qualifications and reference and police checks. Staff receive on-going training supported by the Summerset head office. The in-service program is implemented and attendance records are maintained.</p> <p>Medication competencies have been completed by caregivers who administer medication.</p> <p>Two caregivers interviewed confirmed access to sufficient training.</p> <p>D17.7d: There are implemented competencies for registered nurses related to specialised procedure or treatment including (but not limited to); medication, pain, privacy, preventing elderly abuse and restraint. The Clinical Nurse Leader completed her competencies as part of her orientation to the service.</p>
Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	<p>Two caregivers interviewed reported that staffing levels and the skill mix were appropriate and safe.</p> <p>The Village Manager and the Clinical Nurse Leader work fulltime. Clinical Nurse Leader is on-call for clinical issues and the Village Manager is available after hours for non-clinical service issues.</p> <p>Roster includes 1x 8 hour shift and 1x 5 hour caregiver shift in the morning, and 1x 8 hour and 1x 6 hour caregiver shift in the afternoon and two caregivers are rostered eight hours overnight.</p> <p>Staff turnover is reported by the Village Manager as low. Five residents and two relatives confirm that there is sufficient staff on duty. There are housekeeping and kitchen staff. There is also the village support team who are involved in the everyday running of the village.</p>
Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely	FA	There are policies and protocols in place to manage the safe and appropriate prescribing, dispensing, administration, review, storage and disposal of medicines in

<p>manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>order to comply with legislation, regulations and guidelines. There is a contract with the pharmacy. Medication has been checked on arrival to the facility by the Clinical Nurse Leader. All medications are kept in the locked treatment room. Medication fridge temperature is recorded daily. Resident medication charts included photographs. If identification of any allergies occurs this was documented on the medication charts. There are no residents self-administering their medication.</p> <p>10 individual resident's medication charts reviewed showed that five out 10 medication charts did not evidence three monthly GP reviews. (link CAR-1.3.3.3)</p> <p>Medication is administered by the Clinical Nurse Leader or the medication competent caregivers. Two caregivers interviewed stated that they maintained their medication competency and they described their responsibilities in regard to each stage of medicine management. Staff file reviewed included up to date medicine competencies.</p> <p>Medication management training was provided to staff in July 2014. Medication incidents are investigated as per the medication error management procedure. The facility includes medication errors in their accident and incident reporting.</p> <p>One resident required medication that needed on-going monitoring of therapeutic dose levels and regular laboratory tests. These were appropriately managed. Review of signing sheets shows compliance with the prescribed dose.</p> <p>Medication round (lunch time) was observed and staff found to be compliant with safe medication administration guidelines. Medication audits have been conducted.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>Food is prepared on site in the village café. The kitchen is well maintained and clean. A copy of resident's nutritional profiles has been maintained in the kitchen. Resident food satisfaction/dissatisfaction is followed up immediately. This was confirmed by the chef, the Clinical Nurse Leader, two caregivers and five residents.</p> <p>On admission, the Clinical Nurse Leader completes a dietary profile and communicates individual resident's needs to the kitchen staff.</p> <p>Residents with special dietary needs have these needs reviewed as part of the six monthly care planning review process. Audit of the main kitchen noted that fridge and freezer temperatures were monitored and were within acceptable limits. This is an improvement since the previous audit. There is a daily cleaning schedule in place. All food in the fridge and pantry was dated and labelled.</p>

		<p>Resident interview confirmed satisfaction with food services. A resident satisfaction survey includes food services and residents rated food services 4.0 out of 5 in 2014 survey.</p> <p>D19.2 Staff have been trained in safe food handling.</p>
Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	<p>The Clinical Nurse Leader or the RN is responsible for completing the resident's care plans. Five files sampled evidenced the care plans record appropriate interventions based on the assessed needs, desired outcomes and/or goals of the residents. The required encouragement, direction, or supervision of a resident completing an intervention themselves was recorded in the care plans sampled.</p> <p>There is a short-term care plan that is used for acute or short-term changes in health status. Caregivers record residents care requirements on each shift and this is evaluated by the Clinical Nurse Leader (evidenced in all five residents' progress notes sighted). When a resident's condition alters, the Clinical Nurse Leader or an RN initiates a review and if required, GP or specialist consultation. All the required interventions were documented including the development of short term care plans and records of required observations in the progress notes.</p> <p>Five residents and two families interviewed were complimentary of the care received at the facility.</p> <p>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.</p> <p>Continence management in-services and wound management and pressure area care in-service have been provided to staff.</p> <p>There are two residents with wounds and both of the wounds have been monitored by the Clinical Nurse Leader and reviewed by the GP. Wound assessment and treatment plans were current and complete. The Clinical Nurse Leader interviewed described the referral process and related form should she requires assistance from a wound specialist or continence nurse.</p>

<p><b>Standard 1.3.7: Planned Activities</b></p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>Activities coordinator works 20 hours a week. Volunteers and the caregiving staff assist implementation of the activities programme. A monthly programme was displayed around the facility. Resident's activities participation was recorded and evaluated. Recreational progress notes have been maintained. There is a range of activities offered, that reflect the resident needs and interests.</p> <p>The service has a van and outings. Resident interviews confirmed that individual preferences are met and the program is enjoyable.</p> <p>D16.5d Resident files reviewed (five) identified that the individual activity plan was reviewed during a care plan review.</p>
<p><b>Standard 1.3.8: Evaluation</b></p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>D16.4a. Review of five files demonstrated that care plans were up to date, evaluated six monthly and evaluations of previous care plans were documented. This is an improvement since the previous audit. Changes in health status trigger an update on the care plan. GP's review residents at least three monthly or when requested if issues arise or health status changes. There is evidence of allied health professional's involvement where progress is less than expected.</p> <p>Wound management plans were current (two wounds), residents weights were monitored and weight loss and gains were documented in the residents' file. Residents nutritional profiles were up to date and the chef interviewed were aware of resident's nutritional needs. Two caregivers interviewed were both knowledgeable around residents current care needs.</p>
<p><b>Standard 1.4.2: Facility Specifications</b></p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>There is a current Building Warrant of Fitness that expires on 08 October 2015.</p>
<p><b>Standard 3.5: Surveillance</b></p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Infection monitoring is the responsibility of the infection control officer who is the Clinical Nurse Leader. The infection control policy describes routine monthly infection surveillance and reporting. The infection control (IC) programme is appropriate for the size and complexity of the service. The programme was reviewed annually and IC is a standing agenda item at the monthly staff and the quality improvement meetings. Meeting minutes reviewed showed that Infection control issues were communicated to staff.</p>

		IC data is entered on to the infection register then into Summerset intranet (Sway) which generates a monthly analysis of the data. IC is benchmarked against other Summerset facilities. Review of the meeting minutes showed that an infectious outbreak occurred in 2014 and notification to the local DHB and public health services occurred and outbreak management issues were discussed in the staff and quality improvement meetings. IC training was last provided to the staff in December 2014.
Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised.	FA	There are policies around restraint, enablers and the management of challenging behaviours which meet requirements of HDSS 2008. The Clinical Nurse Leader is the restraint co-ordinator with a job description that defines the role and responsibilities. The service does not currently use restraint or enablers. The policy dictates that enablers should be voluntary and the least restrictive option possible. Two caregivers and the Clinical Nurse Leader interview confirmed that they are familiar with restraint minimisation and use of enable process. Staff received training around restraint minimisation and the management in challenging behaviour. Restraint review was completed in December 2014. Summerset at Aotea has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint or enabler use should this be required.

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 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.	PA Low	An initial nursing assessment and care plan was completed within 24 hours of admission. The long term care plan was developed within three weeks of admission. In all resident files sampled the initial nursing assessment and resident's long term care plans were completed and signed off by the Clinical Nurse Leader or an RN. Six monthly reviews were conducted.	(i) One out of five files reviewed showed that the GP had seen the resident four weeks after the admission. (ii) Four out of 10 medication charts reviewed showed three monthly medication reviews by a GP were not documented. (iii) One resident was transferred from the public hospital and the discharge plan required follow up by a GP in three days including a repeat of the lab test. The GP review was completed 12 days after the discharge.	(i) Ensure that a medical assessment is conducted by the GP within 48 hours of admission. (ii) Ensure that three monthly medication reviews are completed and documented by the GP. (iii) Required follow ups are completed following a discharge from another health service in a timely manner.  90 days

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

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

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

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

No data to display

End of the report.