

# Summerset Care Limited - Summerset in the Vines

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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:

<b>Legal entity:</b>	Summerset Care Limited
<b>Premises audited:</b>	Summerset in the Vines
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 20 May 2015    End date: 20 May 2015
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	41

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

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 27 hospital residents and 14 rest home residents.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the District Health Board. This audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management, staff and a general practitioner.

Summerset in the Vine's village manager (RN) and nurse manager (RN) are experienced in aged care and are supported by a team of registered nurses. The service continues to implement the Summerset quality and risk management system.

Three of the six shortfalls from the previous surveillance audit have been addressed. These are related open disclosure and medication documentation and competencies. Further improvements continue to be required around assessments, care plan interventions, and wound documentation.

This audit identified additional improvements required around restraint 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.
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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.		Standards applicable to this service fully attained.
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Summerset in the Vines continues to implement a quality and risk management system. 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, complaints, infections and internal audit results. The previous shortfall around incident reporting has been addressed. There are implemented human resources policies including recruitment, selection, orientation and staff training and development. The staffing policy aligns with contractual requirements and includes skill mixes.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Assessments, care plans and evaluations are completed by the registered nurses. Risk assessment tools and monitoring forms are available. 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. Short term care plans are used for short term health issues. Care planning interventions and wound care documentation continue to require improvement. There is activities programme across seven the week. There is a medication management system in place. Improvements have been made since previous audit around medication documentation and competencies. Meals are prepared on-site by a catering contractor. Individual and special dietary needs are catered for.

## 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, and reactive and planned maintenance is maintained.

## 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.		Some standards applicable to this service partially attained and of low risk.
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The restraint policy and procedure has a clear definition of restraint and enablers. There are eight residents requiring restraint and two utilising enablers. Staff receive education related to restraint minimisation during orientation and as part of the education programme.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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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. A 2014 annual review of infections has been completed.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	14	0	3	1	0	0
<b>Criteria</b>	0	39	0	3	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has in place a complaints policy and procedure that aligns with Code 10 of the Code of Rights and is an integral part of the quality and risk management system. The village manager is responsible for ensuring complaints are addressed within the required timeframe and maintains contact with the complainant throughout the complaints process. The nurse manager is involved in any complaints regarding care. All complaints are entered into 'SWAY' (Somerset Way), an electronic database, where action taken and close out date is recorded. Complaints are discussed at the monthly quality improvement meeting. Complaints forms are visible around the facility. Interview with the village manager and review of the electronic process indicates a total of four complaints (three closed and one open) from care centre residents received YTD. There is evidence of investigation and follow up with complainants.</p> <p>D13.3h. A complaints procedure is provided to residents within the information pack at entry</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with</p>	FA	<p>Full information is provided at entry to residents and family/whanau. Open communication commences upon residents being admitted. There is a policy to guide staff on the process around open disclosure. The village manager and nurse manager office is based within the care centre, both are readily available to residents and families, they promote an open door policy.</p> <p>Accident/incident forms have a section to indicate if family have been informed (or not) of an accident/incident.</p>

<p>consumers and provide an environment conducive to effective communication.</p>		<p>Family interviewed (two) and progress notes confirm family are notified. The service has policies and procedures available guiding access to DHB interpreter services. Residents and family/whanau are provided with this information in resident information packs on admission.</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: Relatives (two hospital) stated they are informed when their family members health status changes.</p> <p>D11.3 The information pack is available in large print and advised that this can be read to residents</p>
<p>Standard 1.2.1: Governance</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>Summersets overall vision is "older New Zealanders should have access to a quality lifestyle in a safe, secure and enjoyable environment at an affordable cost.". The Summerset Group Limited Board of Directors have overall financial and governance responsibility and there is a company strategic business plan in place. . Summerset in the Vines has a 2015 business plan and goals that was developed in consultation with the village manager and nurse manager. The plan is separated into key focus areas, including; 1) business financial goals, 2) resident satisfaction, 3) clinical quality, 4) clinical risk, 5) property and 6) facilitating community feel. The Summerset in the Vines business plan is reviewed regularly throughout the year. There is a full evaluation at the end of the year.</p> <p>Summerset in the Vines provides care for up to 41 residents in the care centre across two service levels (rest home and hospital, all dual purpose beds). On the day of audit there were 14 rest home residents and 27 hospital residents. Summerset in the Vines is certified to provide medical services under the hospital component of its certificate. There were no residents under this component of their certificate.</p> <p>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 improvement meeting at Summerset in the Vines that includes discussion about clinical indicators (e.g. incident trends, infection rates).</p> <p>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 the Summerset Napier facility. She is supported by a nurse manger (registered nurse) who has been in post for over five years. There is a team of registered nurses and care staff.</p> <p>ARC,D17.3di (rest home), D17.4b (hospital): The village manager and nurse manager have maintained at least eight hours annually of professional development activities related to managing a hospital.</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>	<p>FA</p>	<p>Summerset in the Vines has an established quality and risk management system. Policies and procedures are developed at organisational level. The policies and procedures and associated implementation systems 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. Policies are reviewed on a regular basis. The review of meeting minutes/quality reports demonstrate a culture of quality improvements. Quality and risk performance is reported across the facility meetings and a set agenda item for the quality improvement meeting, health and safety, infection control, RN and caregiver meetings.</p> <p>The Summerset group has a 'clinical audit, training and compliance' calendar that has been 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 improvement meeting that includes discussion about clinical indicators (e.g. incident trends, infection rates) and all aspects of the quality programme (link 2.2.5). Summerset in the Vines infection control and health &amp; safety committees both meet three monthly. A report is provided to the quality improvement 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 three caregivers).</p> <p>Resident/family meetings occur three monthly. These meetings are minuted.</p> <p>There is an internal audit plan. Audits include a summary, any issues arising and corrective actions when required. Monthly and annual analysis of results is completed and provided across the organisation. Issues arising from internal audits are developed into a corrective action plan. Corrective action plans are seen to have been closed out,</p> <p>D19.3: There is a Health &amp; Safety 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 Health &amp; Safety rep).</p> <p>D19.2g: Falls prevention strategies are in place that include the analysis of falls incidents, falls assessment for ambulant residents and the identification of interventions on a case by case basis to minimise future falls.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically</p>	<p>FA</p>	<p>Incidents/accidents are investigated and analysis of incident trends occurs. There is a discussion of incidents/accidents at quality improvement meetings, health and safety meetings and staff meetings that include actions to minimise recurrence. Discussions with the service confirms that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications.</p> <p>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. Eight incident forms were reviewed in</p>

<p>recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>detail and all included follow up. This is an improvement since previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>There are human resources policies to support recruitment practices. The recruitment and staff selection process requires that relevant checks, including police checks (as appropriate) are completed to validate the individual's application, qualifications and experience. A copy of registered nurse practising certificates are kept on file. Six staff files were reviewed (two registered nurses, three caregivers, one was the health and safety rep), all had relevant documentation relating to employment. There is a tracking schedule in place to monitor the appraisal process. There is evidence on staff files of appropriate performance management.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme includes documented competencies and induction checklists (sighted in files of newly appointed staff). Staff interviewed (three caregivers) were able to describe the orientation process and believed new staff were adequately orientated to the service.</p> <p>There is an annual education plan that is outlined on the 'clinical audit, training and compliance calendar'. This includes all required education as part of these standards. The plan is being implemented. There is also an expectation care staff engage in the Careerforce programme verified by three caregivers interviewed.</p> <p>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'. Staff interviewed were 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 on-going education programme. There is a staff member with a current first aid certificate on every shift.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from</p>	<p>FA</p>	<p>Sufficient staff are rostered on duty to manage the care requirements of the rest home and hospital residents at the care centre. The village manager and nurse manager are both full-time Monday to Friday.</p> <p>There is at least one registered nurse and one first aid qualified person on each shift. The caregivers interviewed inform there was an additional caregiver that is due to start on 1 June 2015, with this additional support they felt that there would be sufficient staff on duty at all times. The caregivers, residents and relatives interviewed inform there</p>

<p>suitably qualified/skilled and/or experienced service providers.</p>		<p>are sufficient staff on duty at all times.</p> <p>A staff availability list ensures that staff sickness and vacant shifts are filled. Caregivers interviewed confirmed that staff are replaced especially in the weekends. The service has a staffing levels policy implemented.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>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.</p> <p>Twelve medication charts were reviewed and all had been completed correctly including evidence of three monthly reviews. Medication is administered primarily by registered nurses, and they complete an annual competency. Caregivers check controlled drugs and all have current competencies.</p> <p>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 in the fridges, drug trolleys and cupboard were sighted. Pain assessments were alongside medication charts.</p> <p>There is a self-medicating resident's policy available to guide staff practice if required. There is currently no residents self-administering one medicine.</p> <p>The medication shortfalls identified at the previous surveillance and certification have been addressed.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>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) described her role and how staff report nutritional needs of residents. 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). All dry goods are sealed and dated. All perishable goods in the fridges are date labelled. Daily, weekly and monthly cleaning schedules are maintained. Feedback on the service and meals is by direct verbal feedback and through satisfaction surveys. Residents interviewed spoke positively about the meals provided.</p>

		D19.2: Staff working in the kitchen have food handling certificates and receive on-going training
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	PA Low	<p>Six files reviewed identified that clinical risk assessments had been completed on admission and reviewed at least six monthly. Continuing needs/risk assessments are carried out by registered nurses. Needs outcomes and goals of residents were identified through the assessments and four of six files reviewed linked into care plans.</p> <p>Pain assessments were completed on admission in all six files reviewed and had been completed more frequently in the files of three residents reviewed with identified pain. This is an improvement since previous audit. Residents and relatives interviewed report having been involved in the assessment process. There were no residents with identified behaviours that challenge.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	PA Moderate	<p>Residents interviewed (two rest home and three hospital) stated the care was good and 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. There was documented evidence of short term care plans established for changes in health status. Overall, the care plans were completed to support the ADLs of residents, however shortfalls were identified around updating care plans.</p> <p>D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use. Continance 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. Continance management in-services have been provided.</p> <p>There were 12 residents currently with wounds being dressed including four grade 2 pressure areas; (one resident was in hospital at the time of audit). In the documentation reviewed there were gaps in assessment documentation and wound management. This continues to be a recurring area requiring improvement. Registered nurses interviewed could describe wound management and the shortfalls identified were isolated to documentation only.</p> <p>Files reviewed identified resident's weights recorded on admission and monthly thereafter on the monthly weight chart. Interventions for weight loss were included in the long term care plan. The dietitian can be accessed through the external kitchen provider service. Food and hydration records were noted to be in use as required.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service</p>	FA	<p>There are two activity staff that share activity hours and provide an activities programme across seven days. The activities programme is displayed throughout the facility and interviews with residents confirmed satisfaction with the overall programme. The DT described providing one on one time with those who choose not to participate in the activities or are physically unable. Residents go out to community events such as concerts. Special events, festive</p>

<p>delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>occasions and birthdays are celebrated. There are weekly van outings and residents provide feedback and suggestions for the outings. Monthly resident meetings and surveys allow an opportunity to provide input into the programme.</p> <p>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. Six files sampled had individual documented activity plans</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Four of the six files reviewed had been in the service longer than six months and all had care plan evaluations completed. Care plan evaluations reflecting changes in health status had been updated in care plans (link 1.3.6.1). Short term care plans were utilised to manage acute and short-term issues. These were well documented and noted to be linked to (but not limited to) wounds, incidents/accidents, current infections and pain.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>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 26 February 2016. Hot water temperatures are recorded monthly and are maintained below 45 degrees Celsius. A visual Inspection of the facility provides evidence of safe storage of medical equipment. ARC D15.3: The three caregivers reported they have adequate equipment to provide the care documented in the care plans. Outdoor areas are well maintained.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection</p>	<p>FA</p>	<p>Infection monitoring is the responsibility of the IC officer who is an RN. The surveillance activities at Summerset in the Vines are appropriate to the acuity, risk and needs of the residents.</p> <p>The IC officer enters infections on to the infection register and data enters infection information into the Summerset database which generates a monthly analysis of the data. The analysis is reported to the monthly staff/QI meetings that include a cross section of staff (minutes viewed). The IC officer uses the information obtained through the surveillance of data to determine infection control education needs within the facility. The analysis of infection trending determines that year on year that infection rates are decreasing in the facility. Definitions of infections are described in the infection control manual. Infection control policies are in place appropriate to the complexity of service provided.</p>

control programme.		
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>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 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 eight residents on restraint (bed rails and lap belts) and two residents with enablers. Documentation reviewed reflects that enablers are voluntary and the least restrictive option.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	PA Low	<p>Approved restraint for each individual is reviewed at least three monthly and as part of the care plan review with family/whanau involvement. Restraint usage across the facility is monitored monthly and discussed at monthly quality meetings and a full six monthly audit is undertaken (also link 1.3.6.1). However documentation does not reflect a comprehensive review as identified in 2.2.5.1.</p>

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.3.3</p> <p>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.</p>	PA Low	<p>ARC D.16.2, 3, and 4: Six resident files sampled (two rest home, four hospital) identified the nurse manager or registered nurse’s completed initial support plan within 24 hours. Four of six resident files sampled identified that the long-term care plan was developed within three weeks. Five of six files includes team reviews held six monthly (one resident was a new admission). All six files sampled included evidence of resident/relative input into the initial assessment, care plan and</p>	<p>(i) Two of five hospital care plans were not completed within 21 days of admission; (ii) one resident identified with type 2 diabetes did not have BSL completed on admission or since admission</p>	<p>(i) Ensure long term care plans are completed within 3 weeks; (ii) Ensure BSLs are completed as required</p> <p>90 days</p>

		reviews. Activity assessments were completed and activities plans are developed by the activities staff and evaluated six monthly		
<p>Criterion 1.3.4.2</p> <p>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.</p>	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. Pain assessments were well documented and this is an improvement since previous audit. Two of six care plans did not reflect current assessed needs.	(i) Rest home resident was identified as a high falls risk but did not have interventions/strategies documented to manage the risk; (ii) Hospital resident with identified (high) falls and pressure risk, did not have these reflected in the care plan.	<p>Ensure identified risks are reflected in care plans by documenting interventions to manage/mitigate these risks.</p> <p>60 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Moderate	All wounds were documented on separate forms. This is an improvement since previous audit. Short term care plans were appropriately documented and linked to wound care management	(1) 11 of 19 current assessment/management plans were not fully completed. These included a) incomplete wound assessments, b) gaps in wound type and size, c) lack or incorrect grades documented for pressure areas; c) documentation gaps between dressing	(i) Ensure wound care documentation is complete; (ii) Ensure care plan interventions

		<p>records where appropriate. However, shortfalls continue to be identified around overall wound care documentation. Registered nurses interviewed described their roles and requirements around documentation. Catheter management was well documented in the file of one resident with a catheter. One resident with a PEG had dietitian input and fluid charts were being utilised.</p> <p>Physiotherapy assessments and reviews were identified in two files reviewed. Monitoring charts were in use for residents requiring further checks such as those with weight loss and restraint.</p> <p>Overall, the care plans were completed to support the ADLs of residents, however in four of six care plans reviewed shortfalls were identified around aspects of care.</p>	<p>changes in two charts.</p> <p>(2) The following shortfalls were identified in four of six care plans reviewed. (i) Rest home resident did not signs and interventions to manage palpations and postural hypotension documented; (ii); Hospital resident (with identified weight loss over last six months) did not have interventions documented to manage the weight loss. Same resident following return from hospital did not have LTCP updated to reflect current health status (although STCPs were documented for aspects of current care); (iii) One hospital resident had interventions in care plan documented to manage fungal infections, however this was not current. Interventions for sticky eyes were not documented and restraint monitoring charts reviewed did not reflect that required monitoring had occurred. (iv) an I&amp;A form completed for a hospital resident had prevention strategies documented around frail skin, these were not updated in the care plan.</p>	<p>reflect and support the current health needs of residents</p> <p>60 days</p>
<p>Criterion 2.2.5.1</p> <p>Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:</p> <p>(a) The extent of restraint use and any trends;</p> <p>(b) The organisation's progress in</p>	PA Low	<p>Use of restraint is discussed at monthly quality meetings and restraint committee. Restraint practices are reviewed on a formal basis every three months for each individual.</p> <p>Documentation/meetings</p>	<p>Restraint meeting minutes reviewed did not consider all those listed in this criterion. Individual evaluations did not consider alternative strategies. A restraint incident was not reviewed through the restraint meeting or evaluated to ensure risk</p>	<p>Ensure documentation reflects that a comprehensive review is undertaken and all components of this criterion</p>

<p>reducing restraint;  (c) Adverse outcomes;  (d) Service provider compliance with policies and procedures;  (e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;  (f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;  (g) Whether changes to policy, procedures, or guidelines are required; and  (h) Whether there are additional education or training needs or changes required to existing education.</p>		<p>reviewed do not reflect a comprehensive review.</p>		<p>are considered  90 days</p>
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display
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End of the report.