# Summerset Care Limited - Summerset Down The Lane

## 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 Down the Lane

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

**Dates of audit:** Start date: 2 August 2016 End date: 3 August 2016

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

**Total beds occupied across all premises included in the audit on the first day of the audit:** 53

# 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 Down the Lane provides rest home and hospital level care for up to 49 residents in the care centre and up to 20 rest home level of care residents in care apartments. On the day of the audit, there were 53 residents.

An experienced non-clinical village manager manages the service. On the day of audit, an experienced roving village manager was covering for the village manager who was on annual leave. The nurse manager/registered nurse has been in the role eight months and has many years’ experience in nursing and management roles. A new clinical nurse leader has been appointed and was receiving orientation to the role. The residents and relative interviewed spoke positively about the care and services provided.

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. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management and staff.

The service has addressed 10 of 14 partial achievements from the previous surveillance audit around open disclosure, complaints management, corrective action plans, adverse events, clinical documentation and meeting timeframes for assessments and care plans, InterRAI and risk assessments, care plan interventions, integration of allied health care requirements into care plans and indications for ‘as required’ medications.

Improvements continue to be required in relation to quality data in meeting minutes, integration of progress notes, implementation of interventions and medication documentation.

There were no new findings at this second surveillance audit.

## 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. |

Residents and relative interviewed report that they are kept informed on all changes to health. Regular residents and relative meetings are held. Residents and their family/whānau are provided with information on the complaints process on admission. Staff are aware of the complaints process and to whom they should direct concerns or complaints. Complaints processes are being implemented, managed and documented.

## Organisational management

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| 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. |

Services are planned and are appropriate to the needs of the residents. A village manager and nurse manager/registered nurse are responsible for the day-to-day operations of the facility. Quality and risk management processes have been established including a site specific quality plan and goals, risk management programme, incident and accident reporting, infection control data, internal audits, surveys, quality and service meetings, and health and safety processes.

Residents receive services from qualified staff. Human resources are managed in accordance with good employment practice, meeting legislative requirements. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an ongoing in-service training programme covering relevant aspects of care. Registered nursing cover is provided 24 hours a day, seven days a week. There are adequate numbers of staff on duty to ensure residents are safe.

## Continuum of service delivery

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| 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. |

The clinical nurse leader and registered nurses completed assessments, InterRAI assessments, resident centred care plans, interventions and evaluations within the required timeframes. Risk assessment tools and monitoring forms were available and implemented. Resident centred care plans were individualised and reflected the resident’s current needs and supports.

A recreational therapist for the rest home and village coordinates and implements an integrated activity programme. The activities meet the individual recreational needs and preferences of the consumer groups. There are outings into the community and visiting entertainers.

There are medicine management policies in place that meets legislative requirements. Staff responsible for the administration of medications completes annual medication competencies and education. The general practitioner reviews the medication charts three monthly.

The food service is contracted to an external company. Resident's individual dietary needs were identified and accommodated. Staff have attended food safety and hygiene training. Residents commented positively on the meals 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 building warrant of fitness in place.

## 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. |

Staff receive training around restraint minimisation, the management of challenging behaviour and complete restraint competencies. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraints and enablers. The service had three residents who voluntarily required enablers and no residents on 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. |

The infection control surveillance programme is appropriate to the size and complexity of the service. Results of surveillance are acted upon, evaluated and used to determine infection control activities, resources and education needs within the facility. This included audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Summerset facilities.

## Summary of attainment

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

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **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 | 14 | 0 | 4 | 0 | 0 | 0 |
| **Criteria** | 0 | 37 | 0 | 4 | 0 | 0 | 0 |

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| --- | --- | --- | --- | --- | --- |
| **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).

|  |  |  |
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| **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 | The complaints policy stated that the village manager has overall responsibility for ensuring all complaints (verbal or written) are fully documented and investigated. An on-line complaints register included relevant information regarding the complaint, including the timeframes for acknowledgement of the complaint investigation, follow-up letters with offer of advocacy and resolution. The number of complaints received each month is reported monthly to staff via the various meetings. The complaints reported corresponded with the complaints on the on-line register. The register is current. The previous finding around the complaints register has been addressed. There have been seven complaints received from February to date for 2016. Concerns raised at resident meetings have been documented, addressed and monitored. There has been one complaint forwarded to the Health and Disability Commissioner in March 2016, which remains open awaiting a third party report. A complaints procedure is provided to residents within the information pack at entry. Feedback forms are available for residents/relatives in various places around the facility. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents (three hospital, two rest home and one respite care resident) and one relative (of rest home respite care resident) stated they were welcomed on entry and were given time and explanation about services and procedures. The relative stated they are kept informed of changes in the resident’s health status and any incidents/accidents. The previous finding around relative notification of incidents/accidents has been addressed. Resident/relative meetings are held regularly. The village manager and the nurse manager have an open door policy.  Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The service has policies and procedures available for access to interpreter services for residents (and their family/whānau). |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The service provides care for up to 49 residents at hospital and rest home level care in the care centre. There are 20 care apartments certified for rest home level of care. On the day of the audit, there were 49 residents in the care centre. All care centre beds are dual-purpose. There were 28 rest home residents including two residents on respite care, and 21 residents at hospital level of care. There were four rest home residents in the care apartments. All permanent residents were under the ARCC. There were no younger people or residents under the medical component of the certified services.  The Summerset Group Limited Board of Directors have overall financial and governance responsibility and there is a company strategic business plan in place. Summerset Down the Lane has a site specific business plan and goals that is developed in consultation with the village manager, nurse manager and regional operations manager (ROM). The quality plan is reviewed regularly throughout the year.  The site includes a retirement village with overall management of the site provided by a village manager. The village manager (non-clinical) and the nurse manager/registered nurse (RN) have been in their roles since December 2015. They are supported by a regional operations manager and support staff at head office including a clinical director. The village manager and nurse manager have attended at least eight hours of education within the last eight months including completion of their induction procedure. The nurse manager has held numerous roles in clinical nursing and management including a clinical director of older persons’ rehabilitation service and has worked within DHB settings. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | The organisation’s clinical quality manager oversees quality. Policies and procedures reflect evidence of regular reviews as per the document control schedule. Policies reflect the imbedding of the InterRAI assessments and pressure injury prevention and management. New and/or revised policies have been made available for staff to read and sign that they have read and understand the changes. Summerset village managers and nurse managers are held accountable for their implementation.  The monthly collating of quality and risk data includes (but is not limited to) residents’ falls (with and without injury), bruises, challenging behaviours, infection rates, skin tears and pressure injury. Data is collated monthly on the SWAY (Summerset way) database, and benchmarked against other Summerset facilities to identify trends. There are a number of facility meetings such as quality, infection control and health and safety, management, restraint and clinical (RN and caregivers). Meeting minutes distributed to staff do not evidence discussion around trends and corrective actions of internal audits and infection events. The previous finding around meeting minutes remains.  A resident satisfaction survey is conducted each year. Results for 2015 reflect analyses of the data with an action plan documented. The 2016 annual survey is not due. Meal satisfaction is monitored through the “happy or not” meal survey following each meal, with evidence of continuing satisfaction.  An annual internal audit schedule was sighted with audits completed as per the schedule. Audits include clinical file and medication audits (link 1.3.12.1) environmental, infection control and service audits. Corrective actions have been raised for non-compliance with re-audits and ongoing monitoring as required. The previous finding around corrective actions has been addressed.  A health and safety officer, who is the property manager, oversees the health and safety programme. The health and safety committee includes representative’s nominated from each area of work. The health and safety representative interviewed (senior caregiver) stated the number of representatives has increased this year and committee meetings are held monthly. Staff have the opportunity to have any health and safety concerns addressed at the meeting and the outcomes are fed back to the staff. Hazard identification forms are available and a current online hazard register is in place. Health and safety representatives conduct a weekly hazard inspection of the workplace. The health and safety officer has attended transition training. Falls prevention strategies are in place that include the identification of interventions on a case-by-case basis to minimise future falls. Sensor mats are utilised. A physiotherapist is contracted for weekly visits for resident concerns and mobility assessments and provides staff training for safe manual handling and hoist use. |
| 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. | FA | Incident and accident data has been collected, analysed and entered into the SWAY database (sighted). Fourteen resident related incident reports for July 2016 were reviewed, which included one fall with injury, four falls without injury, one bruise, one pressure injury and seven skin tears. Incident forms identified timely RN assessment, corrective action and follow-up, which has been signed off by the nurse manager. The previous finding around accident/incident forms for all incidents being completed and entered in the database, including designations has been addressed. Corresponding care plans reviewed included appropriate interventions, repetitive falls screening as appropriate and physiotherapy involvement. Neurological observations were sighted for the one resident with a fall with head injury. Not all falls had been documented in progress notes (link 1.3.3.4). Data is linked to the organisation's benchmarking programme and used for comparative purposes.  Discussions with the service confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. The relevant authorities had been notified in April 2016 for a confirmed norovirus outbreak. A full facility report was completed and the outbreak has been well managed. |
| 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 job descriptions available for all relevant positions that describe staff roles, responsibilities and accountabilities. The practising certificates of nurses and allied health professionals are current. Five staff files were reviewed (two caregivers, two RNs and one diversional therapist - DT). Evidence of signed employment contracts, job descriptions, orientation, and staff training were available for sighting. Annual performance appraisals for staff are regularly conducted. Newly appointed staff complete an orientation that is specific to their job duties. Interviews with five caregivers (four rest home and hospital and one care apartments) described the orientation programme that includes a period of supervision.  There has not been a clinical nurse leader (CNL) for the past two months. A clinical nurse leader, with many years aged care experience, has been appointed and was undergoing orientation on the day of audit with a CNL from another Summerset facility.  The service has a training policy and schedule for in-service education. The in-service schedule is implemented and attendance is recorded. For staff members who are unable to attend education, repeat sessions are held and all staff complete competencies. There are implemented clinical and general competencies for staff which include (but not limited to) safe manual handling, hoist, restraint, infection control, health and safety, fire, and medications. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | Staffing levels and skills mix policy includes documented rationale for determining safe service delivery. The village manager, and nurse manager, work 40 hours per week Monday to Friday and are available on call for any emergency issues or clinical support. The service provides 24-hour RN cover. There are two RNs on morning shift with one overseeing the care apartments. On afternoon shift, there is one RN in the care centre and an enrolled nurse in the care apartments. One RN is on duty on the night shift. There are sufficient numbers of caregivers on each duty to provide care as directed in the care plans. There is a caregiver on each shift in the care apartments. A staff availability list ensures that staff sickness and vacant shifts are covered. Any uncovered RN or caregiver shifts are covered by the preferred agency. An agency RN (interviewed) stated she was well supported by staff and had been orientated to the Summerset facility and clinical policies and was competent in the use of the electronic medication system. Caregivers interviewed confirmed that staff are replaced and there are sufficient staff on duty. Residents and relative interviewed also confirmed that there were sufficient staff on duty. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Low | There are medicine management policies and procedures that align with recognised standards and guidelines for safe medicine management practice in accordance with the Medicines Care Guide for Residential Aged Care 2011. The CNL, RN and senior caregivers are responsible for the administration of medications for rest home and hospital residents. Annual medication competencies are in the process of being completed. Medication competent staff have repeated the electronic medication education on-site and the e-learning modules on-line. Medication in-service has included oxygen therapy and warfarin therapy. Registered nurses complete syringe driver training and competency. All medications were evidenced to be checked on delivery with any discrepancies fed back to the supplying pharmacy. There were no self-medicating residents on the day of audit. Standing orders are not used. All eye drops were dated on opening. The medication fridge is monitored weekly. Temperatures outside of the acceptable range have been reported and corrective actions raised.  Nine resident medication charts (three rest home and six hospital) and corresponding medication administration sheets were reviewed on the electronic medication system. The medication chart and signing sheet for the respite resident was also reviewed. Medication charts had photograph identification and allergy status recorded. Staff recorded the time and date of ‘as required’ medications. All ‘as required’ medications had an indication for use. The previous finding around ‘as required’ medications has been addressed. All medication charts reviewed identified that the GP had reviewed the medication chart three monthly. Documented monitoring of missed medications does not have the reasons for omission recorded. The previous finding around medication documentation remains. |
| 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 | A contracted food service company provides meals on-site and to the village café. There is an eight-week rotating and seasonal menu approved by the organisational dietitian. Resident likes/dislikes and preferences are known and accommodated with alternative meal options. The meals are delivered in hot boxes to the care centre and they are served from a bain-marie in the care centre kitchenette. Texture modified meals, fortified foods, protein drinks and diabetic desserts are provided. Special diets are catered. The cook receives a dietary profile for each resident. The qualified chef manager (interviewed) is notified of any changes to resident’s dietary requirements, resident preferences. Residents have an opportunity to feedback on the meal service at resident meetings and surveys. The chef manager is involved in the serving of meals and has direct contact with the residents for feedback on meals.  The fridge, freezer and end cooked food temperatures are recorded twice daily. All foods and perishable goods are stored correctly and date labelled. Cleaning schedules are maintained. Chemicals are stored safely within the kitchen. Staff were observed wearing correct personal protective clothing. The chemical provider completes a functional test on the dishwasher monthly.  Staff working in the kitchen have food handling certificates and chemical safety training. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | The initial assessment and clinical risk assessments have been developed with information received on admission, including discussion with the resident and relatives. Clinical risk assessments are completed on admission where applicable, are completed for new changes and reviewed six monthly as part of the InterRAI assessment. Risk assessments include (but not limited to) pressure injury, pain, nutritional, falls, restraint, wound and behaviour assessments. Outcomes of risk assessment tools are used to identify the needs, supports and interventions required to meet resident goals. The InterRAI assessment tool has been utilised for all residents. The previous finding around InterRAI assessments and risk assessments has been addressed. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Resident centred care plans reviewed describe the individual support and appropriate interventions required to meet the resident goals. The care plans reflect the outcomes of risk assessment tools and the InterRAI outcomes identified during the assessment process. Care plans demonstrate service integration and include input from allied health practitioners. The respite care resident has an initial care and support plan in place.  Short-term care plans were in use for changes in health status. These are evaluated regularly and either resolved or if an ongoing problem, added to the long-term care plan. The previous finding around care plan interventions and service integration in care plans has been addressed. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Low | When a resident’s condition changes, the RN initiates a review, and if required, a GP or nurse specialist consultation. The relative and residents interviewed state their expectations and needs are being met and they are kept informed of any health changes. There was documented evidence in the resident files of family notification of any changes to health including infections, accidents/incidents, and medication changes.  Adequate dressing supplies were sighted in the treatment room. Initial wound assessments with ongoing wound evaluations and treatment plans were in place for 16 residents with wounds (lesions, skin tears, surgical and chronic wounds). There were four pressure injuries (two stage one and two stage two) with one stage two facility acquired and three pressure injuries community acquired. All wounds have been re-assessed at least monthly. Evaluation comments were documented at each dressing change to monitor the healing progress. Photos monitor healing and there is evidence of wound nurse specialist input as required. The service has an RN wound champion.  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.  There are a number of monitoring forms and charts available for use. The RN reviews all monitoring charts daily. Interventions had not been implemented for two residents as per the long-term care plan and initial support plan. The previous finding remains around interventions. |
| 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 service employs a diversional therapist and recreational therapist to provide the seven day a week integrated activity programme. The activity team has attended Summerset training sessions and the regional DT group. The integrated rest home (including rest home residents in care apartments) and hospital programme is planned a month in advance and includes set activities with the flexibility to add other activities of interest or suggestions made by residents. Activities meet the recreational needs of the residents ensuring all residents have the opportunity for outings, shopping, and attending community groups and events. One on one therapy occurs daily for residents who choose not to participate in the group activities. Community visitors include monthly entertainers, weekly bible studies, fortnightly church services, stroke club, book club and age concern advocate visits for chats and discussions. Residents are involved in fundraising for charities such as breakfast for breast cancer.  Resident meetings provide an opportunity for residents to feedback on the programme. The DT is involved in the multidisciplinary review, which includes the review of the activity 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 involvement in the review of resident centred care plans. The registered nurses evaluated all initial care plans of the permanent residents within three weeks of admission. Written evaluations were completed six monthly or earlier for resident health changes. There is evidence of multidisciplinary (MDT) team involvement in the reviews including input from the GP and any allied health professionals involved in the residents’ care. Families are invited to attend the MDT review and if they are unable to attend, they are asked for input. The RN has evaluated short-term care plans. The GP completes three monthly reviews. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building has a current building warrant of fitness that expires on 4 December 2016. The care centre is on the first floor and the care apartments are located on the ground floor. |
| 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 | The infection control policy includes a surveillance policy and procedures, process for detection of infection, infections under surveillance, outbreaks and quality and risk management. Infection events are collected monthly and entered onto the SWAY electronic system. The infection control officer provides a monthly infection control report of data, trends and relevant information to the quality improvement team (link 1.2.3.6). The facility is benchmarked against other Summerset facilities of similar size and benchmarking results are fed back to the infection control officer and used to identify areas for improvement. Infection control audits are completed and corrective actions signed off (sighted). Surveillance results are used to identify infection control activities and education needs within the facility.  There has been one confirmed norovirus outbreak in April 2016. A full facility report was completed and the outbreak was appropriately managed. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There are policies around restraints and enablers. The service currently has no residents assessed as requiring the use of restraint and three residents using enablers. Two residents had bedrails, and one resident had a bedrail and a lap belt in use. The three files reviewed evidenced that the residents gave voluntary consent for enablers. The care plans are up to date and identify the risks associated with the use of enablers and monitoring requirements. Two hourly monitoring forms had been completed including cares delivered during the use of enablers. The use of enablers is reviewed six monthly in conjunction with the care plan review. Staff receive training around restraint minimisation that includes annual competency assessments. |

# 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)** |
| Criterion 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | Quality improvement data (eg, falls, skin tears, pressure injuries, infections) is being collected, analysed and evaluated. Graphs of data are displayed on the staff noticeboard with the number of events for each month. Data is benchmarked against other Summerset facilities with targets established. Monthly internal audits take place as per the audit schedule. Documented discussion in meeting minutes around trends, analysis and corrective actions for the outcomes of internal audits and infection events was not evident. | There are gaps in meeting minutes to evidence that discussion has been held around the outcomes of internal audits and infection trends, analysis and corrective actions. | Ensure meeting minute’s document discussion around the reporting of quality data, trends, analysis and corrective actions in regards to infection events and internal audit outcomes.  60 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 | Monitoring of missed medications on the electronic medication system identifies the reason why medications have not been administered. Reports are required to be generated at least monthly. Reports viewed for the last two months identified no recorded reason for missed medications. | Medication monitoring reports had not been generated for the months of June and July of 2016. The June report identified there was no recorded reason for medications not administered for eight doses of warfarin (two residents) and two doses of antibiotics (two residents). The risk is considered low as the July report did not record any missed medications. A training session relating to the identified issue of correctly recording of medications has been completed. | Ensure regular medications reports are generated for the monitoring of not administered medications and corrective actions implemented.  30 days |
| Criterion 1.3.3.4  The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate. | PA Low | Progress notes are maintained daily. The RN writes into the medical continuation notes. Caregivers write into separate progress notes. There is evidence of the RN reviewing the caregivers progress notes daily however, the progress notes reviewed did not link for residents with falls. | Progress notes were reviewed for four residents who had sustained falls in the month of July 2016. The falls incident for two residents had not been documented in the RN or caregiver progress notes. The falls incident for two other residents was documented in the RN progress notes, but not followed through into the caregiver progress notes. | Ensure resident’s falls are documented by the RN and followed through/integrated into the caregiver progress notes.  90 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 Low | Monitoring charts include (but not limited to) pain monitoring, blood sugar levels, weight monitoring, wound evaluations, food and fluid intake, turning charts, hydration charts and behaviour monitoring. Completed charts including RN reviews were sighted. Three of five resident files reviewed demonstrated interventions were in place to monitor care. | 1) One rest home resident in the care apartments did not have a hydration chart in place to monitor fluid restriction required for a medical condition, as per the long-term care plan. 2) The rest home respite care resident did not have a weight taken on admission as required on the initial support plan. | Ensure documented interventions for monitoring of care are implemented and recorded.  90 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.