**Summerset Care Limited - Summerset on Summerhill**

**Current Status:** **02-Sep-13**

**The following summary has been accepted by the Ministry of Health as being an accurate reflection of the** **Surveillance audit conducted against the Health and Disability Services Standards – NZS8134.1:2008; NZS8134.2:2008 & NZS8134.3:2008 on the audit date(s) specified.**

**General overview**

Summerset on Summerhill provides hospital, medical, rest home level care for up to 41 residents. There has been an increase of one hospital bed since the certification audit. On the day of audit there were 13 rest home residents (included one respite resident) and 28 hospital residents.

The village manager has been in the role for one month. The village manager has a background of working in Human Resource (HR) management and then as the Manager of Age Concern for seven years. She is supported by a nurse manager who has been working at the facility for four months. There are job descriptions for both positions that include responsibilities and accountabilities. Summerset's regional manager, clinical educator and clinical and quality manager have been providing support to the team at Summerset on Summerhill to ensure a thorough orientation and understanding of Summersets policies and procedures.

The service has addressed three of five shortfalls identified in their previous certification audit, including evaluation of care plans, prompt answering of call bells, and resident self-administration of medication documentation/assessment. However improvements continue to be required in relation to medication management and the completion of internal audits.

This surveillance audit has also identified further improvements are required around care planning, and medication documentation.

**Audit Summary AS AT** **02-Sep-13**

Standards have been assessed and summarised below:

**Key**

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained  |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

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| **Consumer Rights** | Day of Audit02-Sep-13 | Assessment |
| 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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| **Organisational Management** | Day of Audit02-Sep-13 | Assessment |
| 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** |

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| **Continuum of Service Delivery** | Day of Audit02-Sep-13 | Assessment |
| 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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| **Safe and Appropriate Environment** | Day of Audit02-Sep-13 | Assessment |
| 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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| **Restraint Minimisation and Safe Practice** | Day of Audit02-Sep-13 | Assessment |
| 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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| **Infection Prevention and Control** | Day of Audit02-Sep-13 | Assessment |
| 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** |

Summerset on Summerhill

Summerset Care Limited

Surveillance audit - Audit Report[[1]](#footnote-1)

Audit Date: 02-Sep-13

Audit Report

To: HealthCERT, Ministry of Health

|  |  |
| --- | --- |
| **Provider Name** | Summerset Care Limited |

|  |  |  |  |
| --- | --- | --- | --- |
| **Premise Name** | **Street Address** | **Suburb** | **City** |
| Summerset on Summerhill | 180 Ruapehu Drive | Aokautere | Palmerston North |

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| --- |
| **Proposed changes of current services** (*e.g. reconfiguration*)**:** |
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|  |  |
| --- | --- |
| **Type of Audit** | Surveillance audit and (*if applicable*)  |
| **Date(s) of Audit** | **Start Date:** 02-Sep-13 **End Date:** 03-Sep-13 |
| **Designated Auditing Agency** | Health and Disability Auditing New Zealand Limited |

# Audit Team

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Audit Team | Name | Qualification | Auditor Hours on site | Auditor Hours off site | Auditor Dates on site |
| Lead Auditor | XXXXXXX | RN, Auditor certificate | 12.00 | 6.00 | 02-Sept-13 |
| Auditor 1 |       |       |       |       |       |
| Auditor 2 |       |       |       |       |       |
| Auditor 3 |       |       |       |       |       |
| Auditor 4 |       |       |       |       |       |
| Auditor 5 |       |       |       |       |       |
| Auditor 6 |       |       |       |       |       |
| Clinical Expert |       |       |       |       |       |
| Technical Expert |       |       |       |       |       |
| Consumer Auditor |       |       |       |       |       |
| Peer Review Auditor | XXXXXXX |       |       | 1.00 |       |

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| --- | --- | --- | --- | --- | --- |
| **Total Audit Hours on site** | 12.00 | **Total Audit Hours off site** *(system generated)* | 7.00 | **Total Audit Hours** | 19.00 |
| **Staff Records Reviewed** | 8 of 58 | **Client Records Reviewed** *(numeric)* | 7 of 41 | **Number of Client Records Reviewed using Tracer Methodology** | 2of 7 |
| **Staff Interviewed** | 10 of 58 | **Management Interviewed** *(numeric)* | 3 of 3 | **Relatives Interviewed** *(numeric)* | 3 |
| **Consumers Interviewed** | 7 of 41 | **Number of Medication Records Reviewed** | 14 of 41 | **GP’s Interviewed (aged residential care and residential disability)** *(numeric)* | 1 |

# Declaration

I, (full name of agent or employee of the company) XXXXXXX (occupation) Director of (place) Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf ofHealth and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Act.

I confirm that Health and Disability Auditing New Zealand Limitedhas in place effective arrangements to avoid or manage any conflicts of interest that may arise.

Dated this 10 day of October 2013

Please check the box below to indicate that you are a DAA delegated authority, and agree to the terms in the Declaration section of this document.

This also indicates that you have finished editing the document and have updated the Summary of Attainment and CAR sections using the instructions at the bottom of this page.

Click here to indicate that you have provided all the information that is relevant to the audit: 🗷

The audit summary has been developed in consultation with the provider: 🗷

Electronic Sign Off from a DAA delegated authority (*click here*): 🗷

# Services and Capacity

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  | **Kinds of services certified** |
|  |  |  | Hospital Care | Rest Home Care | Residential Disability Care |
| **Premise Name** | **Total Number of Beds** | **Number of Beds Occupied on Day of Audit** | **Number of Swing Beds for Aged Residen-tial Care** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Summerset on Summerhill | 41 | 41 | 41 | 🞏 | 🗷 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 |
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Executive Summary of Audit

General Overview

Summerset on Summerhill provides hospital, medical, rest home level care for up to 41 residents. There has been an increase of one hospital bed since the certification audit. On the day of audit there was 13 rest home residents (included one respite resident) and 28 hospital residents.

The village manager has been in the role for one month. The village manager has a background of working in Human Resource (HR) management and then as the Manager of Age Concern for seven years. She is supported by a nurse manager who has been working at the facility for four months. There are job descriptions for both positions that include responsibilities and accountabilities. Summerset's regional manager, clinical educator and clinical and quality manager have been providing support to the team at Summerset on Summerhill to ensure a thorough orientation and understanding of Summersets policies and procedures.

The service has addressed three of five shortfalls identified in their previous certification audit, including evaluation of care plans, prompt answering of call bells, resident self-administration of medication documentation/assessment. However improvements continue to be required in relation to; medication management and the completion of internal audits.

This surveillance audit has also identified further improvements are required around care planning, and medication documentation.

1.1 Consumer Rights

There is an open disclosure policy which describes ways that information is provided to residents and families/representatives at entry to the service continually and as required. Family are involved care planning and receive and provide on-going feedback. The privacy and dignity of residents is respected. Residents and family meetings are held and resident/relative surveys are completed annually. Regular contact is maintained with family including if an incident/ accident or a change in residents health status occurs. There is an on line complaints register that is maintained. The service has documented complaints and there is evidence of follow up. The complaints register reviewed included verbal and written complaints.

1.2 Organisational Management

There is a quality and risk management programme and process that has been established and implemented. There is an internal audit schedule which is completed. However there is an improvement required as internal audits were not consistently completed as per the planned audit schedule. Quality data gathered includes the use of comprehensive forms and online data entry. Data is collated monthly and trends identified. Corrective actions plans, implementation of plans and resolution occur when trends are identified. There is an improvement required around the signing off of corrective actions plans when they have been completed. There is discussion of quality data and any identified improvements required at monthly quality improvement meetings, health and safety meetings, residents meetings and staff meetings. There is an implemented planned annual in-service programme for all staff that includes monthly training. Staff training records are maintained. Annual performance appraisals are completed. Staff and residents reported that staffing levels are sufficient.

1.3 Continuum of Service Delivery

Assessments, care plans and evaluations are completed by the registered nurses. Risk assessment tools and monitoring forms are available. There is an improvement required around the use of wound care assessments. Care plans demonstrate service integration and are individualised. However improvements are required around weight recordings and the use of short term care plans for changes in health status. Care plans are evaluated six monthly. The diversional therapist and activity coordinator provide an activities programme for the residents that is varied, interesting and involves the families and community.

There are improvements required to the medicine management system to ensure there is consistency in signing for medication at the time of administration, that eye drops are dated at time of opening and that medication charts are archived when no longer current.

Meals are prepared on site by a contracted catering company. Food, fridge and freezer temperatures are recorded. Individual and special dietary needs are catered for. Residents interviewed responded favourably to the food that was provided.

1.4 Safe and Appropriate Environment

The service has a current Warrant of Fitness which expires 24-Jul-14. There is sufficient space to allow the movement residents around the facility using mobility aids or lazy boy chairs. Calls bells were evidenced to be answered promptly.

2 Restraint Minimisation and Safe Practice

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 policy identifies that restraint is used as a last resort. The process of assessment and evaluation of enabler use is included in the policy. There are currently four residents using an enabler. Three residents have requested the use of bed gates and one resident has requested a lap belt as enablers. The service currently has three residents requiring a bed gate that has been assessed as a restraint, and two residents requiring the use of bed gates and a lap belt as a restraint. There are clear guidelines in the policy to determine what is a restraint and what is an enabler. There is a restraint/enabler register (sighted) which is current. The restraint standards are being implemented and implementation is reviewed through internal audits and facility meetings.

3. Infection Prevention and Control

The infection control policy includes a surveillance policy. Infections are included on a monthly resident infection and surveillance report and a monthly report is completed by the infection control officer which is presented at the monthly quality improvement meetings. The infection control programme is linked with the quality management programme and is discussed at the various facility meetings. The infection control data entered on line is reviewed by the Summersets Clinical Quality Manager monthly and any areas for improvement are highlighted and follow up corrective action is discussed with the nurse manager and infection control officer at the relevant facility.

There is close liaison with the GP's that advise and provide feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility.

Summary of Attainment

* 1. Consumer Rights

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.1.1 | Consumer rights during service delivery | Not Applicable | 0 | 0 | 0 | 0 | 0 | 1 |
| Standard 1.1.2 | Consumer rights during service delivery | Not Applicable | 0 | 0 | 0 | 0 | 0 | 4 |
| Standard 1.1.3 | Independence, personal privacy, dignity and respect | Not Applicable | 0 | 0 | 0 | 0 | 0 | 7 |
| Standard 1.1.4 | Recognition of Māori values and beliefs | Not Applicable | 0 | 0 | 0 | 0 | 0 | 7 |
| Standard 1.1.5 | Recognition of Pacific values and beliefs |   | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.1.6 | Recognition and respect of the individual’s culture, values, and beliefs | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.1.7 | Discrimination | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.1.8 | Good practice | Not Applicable | 0 | 0 | 0 | 0 | 0 | 1 |
| Standard 1.1.9 | Communication | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.1.10 | Informed consent | Not Applicable | 0 | 0 | 0 | 0 | 0 | 9 |
| Standard 1.1.11 | Advocacy and support | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.1.12 | Links with family/whānau and other community resources | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.1.13 | Complaints management | FA | 0 | 2 | 0 | 0 | 0 | 3 |

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| Consumer Rights Standards (of 12): N/A:10 CI:0 FA: 2 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 48): CI:0 FA:4 PA:0 UA:0 NA: 0 |

* 1. Organisational Management

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.2.1 | Governance | FA | 0 | 2 | 0 | 0 | 0 | 3 |
| Standard 1.2.2 | Service Management | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.2.3 | Quality and Risk Management Systems | PA Low | 0 | 7 | 1 | 0 | 0 | 9 |
| Standard 1.2.4 | Adverse event reporting | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.2.5 | Consumer participation |   | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.2.6 | Family/whānau participation |   | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.2.7 | Human resource management | FA | 0 | 4 | 0 | 0 | 0 | 5 |
| Standard 1.2.8 | Service provider availability | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.2.9 | Consumer information management systems | Not Applicable | 0 | 0 | 0 | 0 | 0 | 10 |

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| Organisational Management Standards (of 7): N/A:2 CI:0 FA: 4 PA Neg: 0 PA Low: 1 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 34): CI:0 FA:16 PA:1 UA:0 NA: 0 |

* 1. Continuum of Service Delivery

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.3.1 | Entry to services | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.3.2 | Declining referral/entry to services | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.3.3 | Service provision requirements | FA | 0 | 3 | 0 | 0 | 0 | 6 |
| Standard 1.3.4 | Assessment | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.3.5 | Planning | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.3.6 | Service delivery / interventions | PA Low | 0 | 0 | 1 | 0 | 0 | 5 |
| Standard 1.3.7 | Planned activities | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 1.3.8 | Evaluation | PA Low | 0 | 1 | 1 | 0 | 0 | 4 |
| Standard 1.3.9 | Referral to other health and disability services (internal and external) | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.3.10 | Transition, exit, discharge, or transfer | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.3.11 | Use of electroconvulsive therapy (ECT) |   | 0 | 0 | 0 | 0 | 0 | 4 |
| Standard 1.3.12 | Medicine management | PA Moderate | 0 | 3 | 1 | 0 | 0 | 7 |
| Standard 1.3.13 | Nutrition, safe food, and fluid management | FA | 0 | 3 | 0 | 0 | 0 | 5 |

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| Continuum of Service Delivery Standards (of 12): N/A:6 CI:0 FA: 3 PA Neg: 0 PA Low: 2 PA Mod: 1 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 51): CI:0 FA:11 PA:3 UA:0 NA: 0 |

* 1. Safe and Appropriate Environment

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.4.1 | Management of waste and hazardous substances | Not Applicable | 0 | 0 | 0 | 0 | 0 | 6 |
| Standard 1.4.2 | Facility specifications | FA | 0 | 3 | 0 | 0 | 0 | 7 |
| Standard 1.4.3 | Toilet, shower, and bathing facilities | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.4.4 | Personal space/bed areas | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.4.5 | Communal areas for entertainment, recreation, and dining | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.4.6 | Cleaning and laundry services | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.4.7 | Essential, emergency, and security systems | FA | 0 | 1 | 0 | 0 | 0 | 7 |
| Standard 1.4.8 | Natural light, ventilation, and heating | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |

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| Safe and Appropriate Environment Standards (of 8): N/A:6 CI:0 FA: 2 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 36): CI:0 FA:4 PA:0 UA:0 NA: 0 |

1. Restraint Minimisation and Safe Practice

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|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 2.1.1 | Restraint minimisation | FA | 0 | 1 | 0 | 0 | 0 | 6 |
| Standard 2.2.1 | Restraint approval and processes | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 2.2.2 | Assessment | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 2.2.3 | Safe restraint use | Not Applicable | 0 | 0 | 0 | 0 | 0 | 6 |
| Standard 2.2.4 | Evaluation | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 2.2.5 | Restraint monitoring and quality review | Not Applicable | 0 | 0 | 0 | 0 | 0 | 1 |
| Standard 2.3.1 | Safe seclusion use |   | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 2.3.2 | Approved seclusion rooms |   | 0 | 0 | 0 | 0 | 0 | 4 |

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| Restraint Minimisation and Safe Practice Standards (of 6): N/A: 5 CI:0 FA: 1 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 21): CI:0 FA:1 PA:0 UA:0 NA: 0 |

1. Infection Prevention and Control

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|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 3.1 | Infection control management | Not Applicable | 0 | 0 | 0 | 0 | 0 | 9 |
| Standard 3.2 | Implementing the infection control programme | Not Applicable | 0 | 0 | 0 | 0 | 0 | 4 |
| Standard 3.3 | Policies and procedures | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 3.4 | Education | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 3.5 | Surveillance | FA | 0 | 2 | 0 | 0 | 0 | 8 |
| Standard 3.6 | Antimicrobial usage |   | 0 | 0 | 0 | 0 | 0 | 5 |

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| Infection Prevention and Control Standards (of 5): N/A: 4 CI:0 FA: 1 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 29): CI:0 FA:2 PA:0 UA:0 NA: 0 |

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| **Total Standards (of 50) N/A:** 33 **CI:** 0 **FA:** 13 **PA Neg:** 0 **PA Low:** 3 **PA Mod:** 1 **PA High:** 0 **PA Crit:** 0 **UA Neg:** 0 **UA Low:** 0 **UA Mod:** 0 **UA High:** 0 **UA Crit:** 0**Total Criteria (of 219) CI:** 0 **FA:** 38 **PA:** 4 **UA:** 0 **N/A:** 0 |

# Corrective Action Requests (CAR) Report

Provider Name: Summerset Care Limited

Type of Audit: Surveillance audit

Date(s) of Audit Report: Start Date:02-Sep-13 End Date: 03-Sep-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXX

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| --- | --- | --- | --- | --- |
| **Std** | **Criteria** | **Rating** | **Evidence** | **Timeframe** |
| 1.2.3 | 1.2.3.8 | PALow | **Finding:**(i)Internal audits were not completed as per audit schedule between January and May 2013, from May onwards audits have been documented as undertaken according to schedule . (ii) Audits were not consistently signed off by the village manager when corrective actions have been completed. (iii) a corrective action plan was not completed for improvements identified through the resident survey completed in November 2012.**Action:**(i) Continue with the process of ensuring that internal audits are completed as per audit schedule. (ii) Ensure that corrective actions are signed and dated when completed. (iii) ensure that a corrective action plan is completed for improvements that are required to be implemented/addressed.  | 3 months |
| 1.3.6 | 1.3.6.1 | PALow | **Finding:**Wound care charts were not evidenced to be fully completed. Size and type of wound were not evidenced to be consistently documented on wound assessment forms. **Action:**Ensure wound care assessment forms document the type and size of wound being treated. | 3 months |

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| --- | --- | --- | --- | --- |
| 1.3.8 | 1.3.8.3 | PALow | **Finding:**(i)A short term care plan was not evidenced completed for a rest home resident on return from public hospital where there were changes to the plan of care (link to 1.3.3). (ii) Long term care plan reviewed for one resident stated that the "resident stays on top of bed all day'. Discussion with caregivers state that the resident now gets up for meals. This change was not reflected in the residents care plan or by use of a short term care plan. (ii) A recent Waterlow assessment score for one resident was recorded as 28 however the care plan stated 18.**Action:**(i), (ii) and (iii) Ensure that changes residents plan of care are updated by the use of a short term care plan or documented in the long term care plan. | 3 months |
| 1.3.12 | 1.3.12.6 | PAModerate | **Finding:**(i)Gaps for signing on administration of medication were observed in four of fourteen medication signing charts reviewed.(ii) Eye drops were not dated when opened (iii) Multiple copies of faxed medication charts were evidenced in three of fourteen medication charts reviewed. It was difficult to assess which was the most recent fax copy received as copies no longer in use were not archived. **Action:**(i)Ensure medications are signed for at time of administration (ii) ensure bottles of eye drops are dated on opening (iii) ensure only the most recent copy of medication chart is kept in medication folder. | immediately -one month |

# Continuous Improvement (CI) Report

Provider Name: Summerset Care Limited

Type of Audit: Surveillance audit

Date(s) of Audit Report: Start Date:02-Sep-13 End Date: 03-Sep-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXX

**1. HEALTH AND DISABILITY SERVICES (CORE) STANDARDS**

**OUTCOME 1.1 CONSUMER RIGHTS**

Consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilitates informed choice, minimises harm, and acknowledges cultural and individual values and beliefs.

**STANDARD 1.1.9 Communication**

Service providers communicate effectively with consumers and provide an environment conducive to effective communication.

ARC A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1b.ii; D16.4b; D16.5e.iii; D20.3 ARHSS A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1bii; D16.4b; D16.53i.i.3.iii; D20.3

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

There is an open disclosure policy which describes ways that information is provided to residents and families. There is an admission pack that gives a comprehensive range of information regarding the scope of service provided to the resident and their family/whānau on entry to the service. The pack includes a copy of the code of rights. This information is discussed at entry and registered nurses and manager are available whenever the family members wish to discuss any aspect of service delivery. Family are involved in the initial care planning and receive and provide ongoing feedback.

Regular contact is maintained with family including if an incident or care/ health issues arises. Family members interviewed (two rest home and one hospital) stated they were well informed and involved in residents care. Seven residents and three family members interviewed confirmed the admission process and agreements documentation were discussed with them. Family state the service provides an environment that encourages open communication.

The admission agreement covers all the areas for the services contractual requirements. All seven resident files reviewed included signed admission agreements completed on the date of admission.

Discussions with six caregivers (working a variety of morning and afternoon shifts) identified their knowledge around open disclosure and reporting to the registered nurse or nurse manager who in turn contacts family. There are resident meetings held two monthly. Minutes are maintained and show follow-up actions for resolution of matters raised. Annual relative/resident surveys are also completed. Surveys completed in November 2012 show that there were some areas for improvement identified and this was discussed at the quality committee meeting and resident meeting.

There are quiet seating areas/lounges at the end of each of the wings. Privacy and sufficient time for discussion can be obtained in resident’s rooms if needed, or by using the designated visitors/residents lounge/library.

D12.1 Non-Subsidised residents/family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry

D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.

D16.4b: Three family members stated that they are always informed when their family member’s health status changes wither by telephone, email or when they come to visit.

D11.3 The information pack is available in large print and advised that this can be read to residents.

**Criterion 1.1.9.1 Consumers have a right to full and frank information and open disclosure from service providers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.9.4 Wherever necessary and reasonably practicable, interpreter services are provided.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.13 Complaints Management**

The right of the consumer to make a complaint is understood, respected, and upheld.

ARC D6.2; D13.3h; E4.1biii.3 ARHSS D6.2; D13.3g

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

The village manager is responsible for ensuring all complaints (verbal or written) are fully documented and thoroughly investigated.

The complaints procedure is provided to resident/relatives at entry and also prominent around the facility on noticeboards. There is an electronic complaints register that is up to date and includes relevant information regarding the complaint. Documentation including follow up letters and resolution demonstrates that complaints are well managed. Verbal complaints are also included and actions and response are documented. Discussion with seven residents and three relatives confirmed they were provided with information on complaints and complaints forms and one family member described having a concern addressed immediately. Complaint forms were visible for residents/relatives in various places around the facility. Seven complaints were reviewed. Five written complaints and two verbal complaints were reviewed for 2012- 2013. All complaints were well documented including investigation, follow up, feedback (verbal, letter) and resolution. Positive communication and Complaints education was provided July 2013 and 14 staff attended.

**Criterion 1.1.13.1 The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.13.3 An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.2 ORGANISATIONAL MANAGEMENT**

Consumers receive services that comply with legislation and are managed in a safe, efficient, and effective manner.

**STANDARD 1.2.1 Governance**

The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.

ARC A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.3d; D17.4b; D17.5; E1.1; E2.1 ARHSS A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.5

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

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.". There is a site specific business plan that is compiled on consultation with the village manager and operations manager (OM). The plan is separated into sections and focus areas, including a) financial goals, b) property, c) clinical quality, d) health and safety, e) infection control, f) human resources, g) sales and marketing, and h) risk. Additionally, each facility develops an annual quality plan.(sighted).

Summerset on Summerhill provides hospital, medical, rest home level care for up to 41 residents. There has been an increase of one hospital bed since the certification audit. There were 13 rest home residents which includes one respite resident and 28 hospital residents. There were no residents at the facility receiving care under a medical contract.

The village manager has been in the role for one month. The village manager has a background of working in HR management in local government for 10 years and then as the Manager of Age Concern for seven years. She is supported by a nurse manager (RN) who has been working at the facility for four months. There are job descriptions for both positions that include responsibilities and accountabilities. Village managers and nurse managers attend annual organisational forums and regional forums six monthly.

There is an operations manager who is available to support the facility and staff. Advised by the village manager that the operations manager visits at least four weekly and is available to be contacted by telephone or email as required. As the village manager is new to the position there has been more frequent visits occurring to ensure a thorough orientation.

Summersets Clinical and Quality Manager who was on site during the audit advised that the nurse manager has been supported by Summerset’s Clinical Educator who has been based at the facility for the last four months.

Policies and procedures are developed at an organisational level with input from staff and external specialist expertise where required.

D17.3di (rest home) & D17.4b (hospital), the manager has maintained at least eight hours annually of professional development activities related to managing a hospital.

**Criterion 1.2.1.1 The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.1.3 The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

ARC A4.1; D1.1; D1.2; D5.4; D10.1; D17.7a; D17.7b; D17.7e; D19.1b; D19.2; D19.3a.i-v; D19.4; D19.5 ARHSS A4.1; D1.1; D1.2; D5.4; D10.1; D16.6; D17.10a; D17.10b; D17.10e; D19.1b; D19.2; D19.3a-iv; D19.4; D19.5

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** PA Low

Summerset on Summerhill has an established quality and risk management system. Interviews with staff and review of meeting minutes/quality reports demonstrate a culture of quality improvements. Quality and risk performance is reported across the facility meetings.

The village managers’ report covers staffing, business and risk plan progress, financial, village occupancy, audits (external), complaints and compliments, survey results and resident meetings

The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The facility has a master copy on computer of all policies & procedures with a master also of clinical forms filed in folders alphabetically. These documents have been developed in line with current accepted best and/or evidenced based practice and are reviewed regularly by Summersets Clinical and Quality Manager. The content of policy and procedures are detailed to allow effective implementation by staff. A number of core clinical practices also have education packages for staff which are based on their policies. Discussion regarding policy development/revision occurs at staff meetings. Release of updated or new policy/procedure/audit/education occurs across the organisation (sighted). The release is notified by email to all village managers and nurse managers identifying a brief note of which documents are included at that time. There is a policy/procedure sign off sheet to use within the facilities for staff to sign as having noted/read the new/reviewed policy.

 Key components of the quality management system link to the monthly quality improvement meetings. There is a standing agenda for monthly quality improvement meetings. These include discussion of residents care issues, clinical updates, audit results and corrective action plans, improvement projects, complaints/compliments, policies and reviews, staff training, supplier performance and any other business. Weekly and monthly reports by village manager to the operations manager and Summersets support office provide a coordinated process between service level and organisation.

The service has a variety of monthly meetings to ensure organisational performance is monitored. These include a monthly health and safety meeting which includes infection control, a monthly restraint meeting, a monthly quality improvement meeting and monthly staff meetings and monthly RN meetings. There is an internal audit plan. Audits include a summary, any issues arising and corrective actions when required.

There are monthly accident/incident benchmarking reports completed by the nurse manager that break down the data collected across the rest home and hospital and staff incidents/accidents. Infection control is also included as part of benchmarking across the organisation. Health and safety committee meets monthly and Health and safety is also an agenda item at the quality improvement meetings. Health and safety and incident/accidents, internal audits are completed. Annual analysis of results is completed and provided across the organisation.

The monitoring programme includes (but not limited to); environment, kitchen, medications, care and hygiene, documentation, moving and handling, code of rights, weight management, H&S, accident reporting documentation, care planning and infection control. Frequency of monitoring is determined by the internal audit schedule. Audit summaries and action plans are completed where a noncompliance is identified. Issues are reported to the appropriate committee e.g. quality. Summersets Clinical and Quality Manager analyses data collected via the monthly reports and corrective actions are required based on benchmarking outcomes. Feedback is provided to the facility via graphs and benchmarking reports. Benchmarking reports are generated throughout the year to review performance over a 12 month period. Quality Improvement forms are utilised and document actions that have improved outcomes or efficiencies in the facility. The service continues to collect data to support the implementation of corrective action plans. Responsibilities for corrective actions are identified. Reports provided to the quality meeting (such as health and safety and infection control) include areas identified for improvement and actions initiated.

Results from resident survey completed in November 2012 were discussed at QI meeting. However a corrective action form was not competed to address improvements identified. In the previous audit, internal audits were not completed as per scheduled. A review of audits between January and May 2013 identified that internal audits continue to not be completed as per the audit schedule. Therefore this partial remains open.

D19.3:There is a comprehensive H&S and risk management programme in place.

D19.2g Falls prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls. Strategies and equipment available to minimise falls risk are hi low beds, floor sensor mats, nurse call bells and mobility aids.

**Criterion 1.2.3.1 The organisation has a quality and risk management system which is understood and implemented by service providers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.3 The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.4 There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.5 Key components of service delivery shall be explicitly linked to the quality management system.**

 This shall include, but is not limited to:

 (a) Event reporting;

 (b) Complaints management;

 (c) Infection control;

 (d) Health and safety;

 (e) Restraint minimisation.

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.7 A process to measure achievement against the quality and risk management plan is implemented.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.**

**Audit Evidence** **Attainment:** PA **Risk level for PA/UA:** Low

Internal audits were evidenced to be completed. Quality improvements are identified via resident surveys, internal audits, resident and staff and quality meetings. Corrective actions plans were evidenced completed for any improvements identified.

**Finding Statement**

(i)Internal audits were not completed as per audit schedule between January and May 2013, from May onwards audits have been documented as undertaken according to schedule. (ii) Audits were not consistently signed off by the village manager when corrective actions have been completed. (iii) a corrective action plan was not completed for improvements identified through the resident survey completed in November 2012.

**Corrective Action Required:**

(i) Continue with the process of ensuring that internal audits are completed as per audit schedule. (ii) Ensure that corrective actions are signed and dated when completed. (iii) ensure that a corrective action plan is completed for improvements that are required to be implemented/addressed.

**Timeframe:**

3 months

**Criterion 1.2.3.9 Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:**

 (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;

 (b) A process that addresses/treats the risks associated with service provision is developed and implemented.

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

ARC D19.3a.vi.; D19.3b; D19.3c ARHSS D19.3a.vi.; D19.3b; D19.3c

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

There is an accident and incident policy. Incidents, accidents are investigated and analysis of incidents trends occurs. There is a discussion of incidents/accidents at management, staff and registered nurse and quality improvement committee meetings including 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. There is an open disclosure policy and three family members interviewed stated they are informed of changes in health status and incidents/accidents. Incident reports for August 2013 were reviewed. The August 2013 monthly incident/accident analysis form observed completed, documents date, name of resident, place, time, site/area of facility, type of incident/accident, any injury, contributing factors and if a resident, staff or visitor. This data is entered online. There were 14 incidents/accidents documented as occurring in August 2013. All incidents reviewed document that there is RN follow up and review of incident. Six of the incidents were traced back to the care plans and progress notes of respective residents. All reflected the incident and documented registered nurse assessment any emergent treatment given, preventative measures to be implemented (where appropriate) and contact with family/whanau. Two registered nurses and nurse manager interviewed advised that staff are in regular contact with family and this is confirmed by review of entries in family contact sheets evidenced in resident files reviewed. Monthly incident/accident analysis occurs with subsequent annual summary and analysis. D19.3b; there is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing.

**Criterion 1.2.4.2 The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.4.3 The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

ARC D17.6; D17.7; D17.8; E4.5d; E4.5e; E4.5f; E4.5g; E4.5h ARHSS D17.7, D17.9, D17.10, D17.11

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The recruitment and staff selection process requires that relevant checks are completed to validate the individual’s qualifications, experience and veracity. A copy of practising certificates including the registered nurse and general practitioners is kept. There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Eight staff files were reviewed (two registered nurses, four caregivers, one diversional therapist, one cleaner). Reference checks are completed before employment is offered and these were evidenced completed in staff files reviewed. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Six caregivers interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Orientation checklists evident in staff files reviewed. Annual practicing certificates were sighted for registered nurses and general practitioners.

Discussion with the nurse manager, two registered nurses and six caregivers confirm that a comprehensive in-service training programme is in place that covers relevant aspects of care and support and meets requirements. There is an in-service calendar for 2013. The annual training programme exceeds eight hours annually. The registered nurses attend external training including conferences, seminars and sessions provided by the local MCDHB. One registered nurse has completed level 2 PDRP. All registered nurses have completed Nursing Knowledge and Practice modules at MCDHB. The nurse manager has attended education and training sessions from external providers in 2012 and 2013 to date. Education provided in 2013 includes: respiratory and heart disease, code of rights, Manual handling, Treaty of Waitangi, cultural safety, food safety, chemical safety, incontinence, disaster management, ethical issues in palliative care, pain and symptom management, restraint minimisation, trauma and loss and medication. Training occurs at least monthly and records include date, session topic, and names of attendees. There is evidence of session content, evaluations conducted following training and the service advised that those staff who do not attend training are provided with the content of training to read, and are scheduled to attend the next training session.

D17.7d: There are implemented competencies for registered nurses related to specialised procedure or treatment including (but not limited to); Medication, Insulin administration, use of Oxygen, PEG feeding and Syringe driver.

Ten caregivers have completed Career force level 2 Foundation course, three caregivers have National certificate in support of the older person and five caregivers are enrolled on Career force level 2 Foundation course.

**Criterion 1.2.7.2 Professional qualifications are validated, including evidence of registration and scope of practice for service providers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.7.3 The appointment of appropriate service providers to safely meet the needs of consumers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.7.4 New service providers receive an orientation/induction programme that covers the essential components of the service provided.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.8 Service Provider Availability**

Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.

ARC D17.1; D17.3a; D17.3 b; D17.3c; D17.3e; D17.3f; D17.3g; D17.4a; D17.4c; D17.4d; E4.5 a; E4.5 b; E4.5c ARHSS D17.1; D17.3; D17.4; D17.6; D17.8

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

Sufficient staff are rostered on duty to manage the care requirements of the rest home and hospital residents at Summerset on Summerhill. The village manager works 40 hours per week Monday-Friday and is available on call. The nurse manager works 40 hours per week Monday-Friday and is available on call for any emergent issues or clinical support. The service provides 24 hr RN cover. Rosters evidence that extra staff can be called on for increased resident requirements. Interviews with six caregivers, seven residents and three family identify that staffing is adequate to meet the needs of residents.

**Criterion 1.2.8.1 There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.3 CONTINUUM OF SERVICE DELIVERY**

Consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.

**STANDARD 1.3.3 Service Provision Requirements**

Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.

ARC D3.1c; D9.1; D9.2; D16.3a; D16.3e; D16.3l; D16.5b; D16.5ci; D16.5c.ii; D16.5e ARHSS D3.1c; D9.1; D9.2; D16.3a; D16.3d; D16.5b; D16.5d; D16.5e; D16.5i

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

D.16.2, 3, 4: The seven resident files sampled (four hospital and three rest home) identified that the RNs complete an initial assessment within 24 hours. Information gathered on admission from needs assessment form, discharge summaries, nursing care discharge summaries, GP health records and letters, allied health notes, resident/family/whanau participation and involvement provide the basis for the initial assessment and initial support care plan. All seven files sampled identified that the long term support plan is developed within three weeks. There is documented evidence of multidisciplinary reviews held six monthly involving the resident/family/whanau, RN and care staff, medical (including medication review) and where applicable allied health input. The RNs amend the long term support plan to reflect ongoing changes as part of the review process. Allied health professionals involved in the residents care are linked to the support care plan review such as, dietitian, physiotherapist, podiatrist, hospice and continence nurse. All seven resident files sampled documented discussions with family/whanau regarding changes to health, incidents, infections , MDT meetings, and GP visits.

D16.5e: Seven of seven resident files sampled identified that the GP had seen the resident within two working days. It was noted in all resident files sampled that the GP had examined the resident three monthly and carried out a medication review. More frequent medical review is evidenced in files of residents with more complex conditions or acute changes to health status. The GP (interviewed by phone) visits weekly and carries out the three monthly reviews and visits any other residents of concern. The GP is available after hours and there is cover arranged to cover for leave. The GP states he receives prompt notifications of changes to resident health.

All seven resident files sampled identified integration of allied health professionals and a team approach.

There is a verbal handover from RN to RN at the beginning of each shift, the oncoming RN then provides a verbal handover to the caregivers to ensure staff are kept informed of residents health status and any significant events.

Four hospital resident files sampled as follows: 1) resident with a wound (grade II Pressure area), 2) resident with history of falls 3) resident requiring the use of a restraint 4) resident with challenging behaviours.

Three rest home resident file sampled 1) resident who is a new admission, 2) one resident requiring the administration of controlled medications as part of pain management plan and 3) resident who is a high falls risk.

Tracer Methodology: Hospital

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

Rest home.

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

**Criterion 1.3.3.1 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.6 Service Delivery/Interventions**

Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.

ARC D16.1a; D16.1b.i; D16.5a; D18.3; D18.4; E4.4 ARHSS D16.1a; D16.1b.i; D16.5a; D16.5c; D16.5f; D16.5g.i; D16.6; D18.3; D18.4

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** PA Low

The service provides services for residents requiring rest home and hospital level care. Individualised care plans are completed. When a resident's condition alters, the registered nurses initiate a review and if required, GP or specialist consultation. The six caregivers and two registered nurses interviewed stated that they have all the equipment referred to in long and short term care plans necessary to provide care, including hoists, electric beds, pressure relieving mattresses and cushions, shower chairs, transfer belts, wheelchairs, gloves, aprons and masks.

D18.3 and Dressing supplies are available and the medication room holds adequate supplies of wound care products, blood glucose monitoring equipment and other medical equipment. There are adequate supplies of incontinent products in all areas.

Wound assessment and treatment/management plans are in place for eight residents and include; One grade II and two grade I pressure area wounds, three skin tears and two BCC lesions. A tissue viability service report for this wound was sighted completed on 05-Aug-13. Air wave pressure relieving mattress was evidenced on the bed of resident with grade II pressure area.

Education on wound management was provided on 27-Aug-13 with five staff attending. There is an improvement required around the documentation of wound assessments.

Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day and night use. Catheter management plans are used (as sighted) for residents with indwelling catheters. Specialist continence advice is available as needed and the RN on duty could describe the referral process.

All falls are reported on the resident accident/incident form. Coombes falls risk assessments are completed on admission and reviewed at least six monthly or earlier if required. There is evidence of physiotherapist referrals and involvement in resident assessments.

Resident’s weight is recorded on admission and monitored monthly. Chair scales are available and have been calibrated

The Registered Nurses interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse.

**Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.**

**Audit Evidence** **Attainment:** PA **Risk level for PA/UA:** Low

Dressing supplies are available and the medication room holds adequate supplies of wound care products, blood glucose monitoring equipment and other medical equipment. There were wound care plans in place for eight residents with interventions documented to provide care to resident and the wounds Wound assessment and treatment/management plans are in place for eight residents and include; One grade II and two grade I pressure area wounds, three skin tears and two BCC lesions. A tissue viability service report for this wound was sighted completed on 05-Aug-13. Air wave pressure relieving mattress was evidenced on the bed of resident with grade II pressure area

**Finding Statement**

Wound care charts were not evidenced to be fully completed. Size and type of wound were not evidenced to be consistently documented on wound assessment forms.

**Corrective Action Required:**

Ensure wound care assessment forms document the type and size of wound being treated.

**Timeframe:**

3 months

**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.

ARC D16.5c.iii; D16.5d ARHSS D16.5g.iii; D16.5g.iv; D16.5h

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The activities coordinator has five years of experience in this role as a diversional therapist. She is employed for 38 hours a week and has an assistant who works five hours a week. A monthly activities plan is completed with the residents and residents receive a personal copy of planned monthly activities and are reminded of what is happening daily. Activities planners are printed in large print on A3 paper and are displayed on notice boards around the facility. The programme is flexible to meet the recreational preferences of the residents. Outings are scheduled using the company van. There is allocated one on one time for residents who unable or who prefer not to participate in the recreation programme.

Each resident has an individual lifestyle/social profile that is developed with assistance of family and includes a life map of residents interests and life experiences. The profile is reviewed six monthly and daily participation records are maintained. Residents are able to participate in community activities as well as activities in the service itself.

Activities include (but not limited to): outings, exercise, programme, music, crafts, pottery, bingo, guest speakers, shopping trips, happy hour, reading, and quizzes.

Residents were observed to be actively involved in various activities such as crafts, newspaper reading, quizzes and exercises during the 1.5 days of audit.

Residents (seven) and family (three) interviewed confirmed satisfaction around the programme.

**Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.8 Evaluation**

Consumers' service delivery plans are evaluated in a comprehensive and timely manner.

ARC D16.3c; D16.3d; D16.4a ARHSS D16.3c; D16.4a

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** PA Low

Any changes to the long term care plan are dated and signed.

Short term care plans were evidenced completed and evaluated for wounds, weight loss, poor appetite, and infections. However there is an improvement required around the use of short term care plans and updating care plans to reflect the care being delivered.

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

D16.3c: All initial care plans were evaluated by the RN within three weeks of admission.

**Criterion 1.3.8.2 Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.8.3 Where progress is different from expected, the service responds by initiating changes to the service delivery plan.**

**Audit Evidence** **Attainment:** PA **Risk level for PA/UA:** Low

Short term care plans were evidenced completed and evaluated for infections, wounds, weight loss and post falls.

**Finding Statement**

(i)A short term care plan was not evidenced completed for a rest home resident on return from public hospital where there were changes to the plan of care (link to 1.3.3). (ii) Long term care plan reviewed for one resident stated that the "resident stays on top of bed all day'. Discussion with caregivers state that the resident now gets up for meals. This change was not reflected in the residents care plan or by use of a short term care plan. (ii) A recent Waterlow assessment score for one resident was recorded as 28 however the care plan stated 18.

**Corrective Action Required:**

(i), (ii) and (iii) Ensure that changes residents plan of care are updated by the use of a short term care plan or documented in the long term care plan.

**Timeframe:**

3 months

**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.

ARC D1.1g; D15.3c; D16.5e.i.2; D18.2; D19.2d ARHSS D1.1g; D15.3g; D16.5i..i.2; D18.2; D19.2d

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** PA Moderate

The service uses individualised medication blister packs. The medications are delivered monthly and checked in by the nurse manager and another RN. Medication charts record prescribed medications by residents’ general practitioner, including PRN and short course medications.

Medication administration was observed in the hospital and rest home. Medications and associated documentation is kept in the locked medication trolleys. Medication trolleys are stored in a locked treatment room when not in use.

RN's are responsible for administering medication. Medications are reviewed three monthly with medical reviews by the attending GP.

Documentation of reviews is included in medical file section of resident integrated files and on the drug charts.

Controlled drugs are stored in a locked cabinet inside a locked treatment room. Controlled drugs are recorded and checked by two staff members in the controlled drug register. Controlled drugs are checked weekly. The medication fridge is monitored weekly.

Medication reconciliation is completed on admission and the policy includes guidelines on checking on arrival. This was sighted in the new admission rest home file reviewed. Resident photos and allergies are on all the drug charts.

All RNs and caregivers who complete second checks on controlled medications with RNs, complete a medication package. An annual medication administration competency is completed of each staff member. Medication competence assessments were observed in staff files reviewed.

There is a self-medicating resident’s policy in place. A self-medication assessment checklist is available. There are currently no residents self-administering medications. Individually prescribed resident medication charts are in use and this provides a record of medication administration information that complies with relevant recording requirements. The service has in place policies and procedures for ensuring all medicine related recording and documentation is: a) legible, b) signed and dated and c) able to meet acceptable good practice standards.

D16.5.e.i.2; Fourteen medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed.

Improvements are required around medication management.

**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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.12.3 Service providers responsible for medicine management are competent to perform the function for each stage they manage.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.12.5 The facilitation of safe self-administration of medicines by consumers where appropriate.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.12.6 Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.**

**Audit Evidence** **Attainment:** PA **Risk level for PA/UA:** Moderate

Ten of fourteen medication signing charts reviewed were fully completed. Eleven medication charts were current and an original copy.

**Finding Statement**

(i)Gaps for signing on administration of medication were observed in four of fourteen medication signing charts reviewed.(ii) Eye drops were not dated when opened (iii) Multiple copies of faxed medication charts were evidenced in three of fourteen medication charts reviewed. It was difficult to assess which was the most recent fax copy received as copies no longer in use were not archived.

**Corrective Action Required:**

(i)Ensure medications are signed for at time of administration (ii) ensure bottles of eye drops are dated on opening (iii) ensure only the most recent copy of medication chart is kept in medication folder.

**Timeframe:**

Immediately -one month

**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.

ARC D1.1a; D15.2b; D19.2c; E3.3f ARHSS D1.1a; D15.2b; D15.2f; D19.2c

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

Food services at Summerset is contracted and all foods are cooked on site. There are two chefs and one chef assistant/cook. The menu has been reviewed by a dietitian.

On admission the RN completes a dietary profile and communicates individual resident’s needs to the kitchen staff. This information is updated as required. Care plans reviewed (three resthome and four hospital) identify nutritional needs and preferences of residents. Regular monitoring of resident's weight and nutritional needs occur.

Menu planning policy refers to providing residents with a balanced varied diet, which provides for the individual’s health status, personal likes and dislikes, religious or ethnic restrictions and medical modifications.

Discussions with the village manager confirmed that the dietician provides services as required and Summerset has access to a dietitian from the community.

D19.2 staff have been trained in safe food handling.

**Criterion 1.3.13.1 Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.13.2 Consumers who have additional or modified nutritional requirements or special diets have these needs met.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.13.5 All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.4 SAFE AND APPROPRIATE ENVIRONMENT**

Services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensures physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.

These requirements are superseded, when a consumer is in seclusion as provided for by of NZS 8134.2.3.

**STANDARD 1.4.2 Facility Specifications**

Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.

ARC D4.1b; D15.1; D15.2a; D15.2e; D15.3; D20.2; D20.3; D20.4; E3.2; E3.3e; E3.4a; E3.4c; E3.4d ARHSS D4.1c; D15.1; D15.2a; D15.2e; D15.2g; D15.3a; D15.3b; D15.3c; D15.3e; D15.3f; D15.3g; D15.3h; D15.3i; D20.2; D20.3; D20.4

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The building has a current Warrant of Fitness which expires on 24-Jul-14. Preventative maintenance is carried out. There are outdoor seating and garden areas which provide shade. All furniture is purchased to meet the needs of the client groups. Residents were observed to be able to mobilise around the facility with or without mobility aids and support of staff.

**Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.2.4 The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.2.6 Consumers are provided with safe and accessible external areas that meet their needs.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.7 Essential, Emergency, And Security Systems**

Consumers receive an appropriate and timely response during emergency and security situations.

ARC D15.3e; D19.6 ARHSS D15.3i; D19.6

Evaluation methods used: D 🗷 SI 🞏 STI 🞏 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

It was identified at certification audit that call bells were not answered in a timely manner. Call bells were observed to be answered promptly during the 1.5 days of audit. Residents interviewed (7) stated that call bells were answered promptly.

**Criterion 1.4.7.5 An appropriate 'call system' is available to summon assistance when required.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**2. HEALTH AND DISABILITY SERVICES (RESTRAINT MINIMISATION AND SAFE PRACTICE) STANDARDS**

**OUTCOME 2.1 RESTRAINT MINIMISATION**

**STANDARD 2.1.1 Restraint minimisation**

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

There is a documented definition of restraint and enablers which is congruent with the definition in NZS 8134.0. The policy includes comprehensive restraint procedures. The policy identifies that restraint is used as a last resort.

The process of assessment and evaluation of enabler use is included in the policy. There are currently four residents using an enabler. Three residents have requested the use of bed gates and one resident has requested a lap belt as enablers. The service currently has three residents requiring a bed gate that has been assessed as a restraint, and two residents requiring the use of bed gates and a lap belt as a restraint. There are clear guidelines in the policy to determine what is a restraint and what is an enabler. There is a restraint/enabler register (sighted) which is current. The restraint standards are being implemented and implementation is reviewed through internal audits and facility meetings.

**Criterion 2.1.1.4 The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**3. HEALTH AND DISABILITY SERVICES (INFECTION PREVENTION AND CONTROL) STANDARDS**

**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.

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The infection control policy includes a surveillance policy. The surveillance policy includes a surveillance procedure , process for detection of infection, infections under surveillance, outbreaks and quality and risk management.

Infections are included on a monthly resident infection and surveillance report and a monthly report is completed by the infection control officer which is presented at the monthly quality improvement meetings.

Infection control data is collated monthly and is documented as discussed at the various service meetings. The infection control programme is linked with the quality management programme.

All infections are documented on the Summerset infection monthly on line register. The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control data entered on line is reviewed by the Summerset Clinical Quality Manager monthly and any areas for improvement are highlighted and follow up corrective action is discussed with the nurse manager and infection control officer at the relevant facility.

There is close liaison with the GP's that advise and provide feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility.

**Criterion 3.5.1 The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

1. [↑](#footnote-ref-1)