# Summerset Care Limited - Summerset in the River City

## Current Status: 20 November 2013

**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 and NZS8134.3:2008) on the audit date(s) specified.**

## General overview

Summerset in the River City provides hospital and rest home level care for up to 49 residents. On the day of audit there were 18 residents receiving rest home level care rest home (including five residents in serviced apartments) and 20 residents receiving hospital level care.

There is an experienced aged care village manager who has been in the role for three years. He is supported by a nurse manager who has been working at the facility for three months.

The service has addressed seven of eight shortfalls identified at the previous audit. These were around completion of advanced directives, evidence of quality data, internal audits, surveys, meeting minutes, dating and signing documents, restraint risks, evaluation of wounds, completion of orientations and identified aspects of medicine management.

Improvements continue to be required in relation to individualised activity care plans.

This surveillance audit has identified further improvements required around interventions and aspects of medicine documentation.

## Audit Summary as at 20 November 2013

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 |

### Consumer Rights as at 20 November 2013

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| 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. |

### Organisational Management as at 20 November 2013

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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. |  | Standards applicable to this service fully attained. |

### Continuum of Service Delivery as at 20 November 2013

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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. |

### Safe and Appropriate Environment as at 20 November 2013

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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. |

### Restraint Minimisation and Safe Practice as at 20 November 2013

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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. |

### Infection Prevention and Control as at 20 November 2013

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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. |

# HealthCERT Aged Residential Care Audit Report (version 3.91)

## Introduction

This report records the results of an audit against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) of an aged residential care service provider. The audit has been conducted by an auditing agency designated under 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).

It is important that auditors restrict their editing to the content controls in the document and do not delete any content controls or any text outside the content controls.

## Audit Report

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| --- | --- |
| **Legal entity name:** | Summerset Care Limited |
| **Certificate name:** | Summerset in the River City |

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| **Designated Auditing Agency:** | Health and Disability Auditing New Zealand Limited |

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| **Types of audit:** | Surveillance | | | |
| **Premises audited:** | Summerset in the River City, 40 Burton Avenue, Wanganui | | | |
| **Services audited:** | Hospital (medical and geriatric) and rest home | | | |
| **Dates of audit:** | **Start date:** | 20 November 2013 | **End date:** | 21 November 2013 |

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| **Proposed changes to current services (if any):** |
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| **Total beds occupied across all premises included in the audit on the first day of the audit:** |  |

## Audit Team

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| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXXX | **Hours on site** | 13 | **Hours off site** | 6 |
| **Other Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXX |  |  | **Hours** | 2 |

## Sample Totals

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| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 13 | Total audit hours off site | 8 | Total audit hours | 21 |

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| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 3 | Number of staff interviewed | 10 | Number of managers interviewed | 3 |
| Number of residents’ records reviewed | 5 | Number of staff records reviewed | 5 | Total number of managers (headcount) | 3 |
| Number of medication records reviewed | 15 | Total number of staff (headcount) | 50 | Number of relatives interviewed | 4 |
| Number of residents’ records reviewed using tracer methodology | 2 |  |  | Number of GPs interviewed | 0 |

## Declaration

I, XXXXX, Director of Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of the Designated Auditing Agency named on page one of this report (the DAA), an auditing agency designated under section 32 of the Act.

I confirm that:

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| a) | I am a delegated authority of the DAA | Yes |
| b) | the DAA has in place effective arrangements to avoid or manage any conflicts of interest that may arise | Yes |
| c) | the DAA has developed the audit summary in this audit report in consultation with the provider | Yes |
| d) | this audit report has been approved by the lead auditor named above | Yes |
| e) | the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook | Yes |
| f) | if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider | Yes |
| g) | the DAA has provided all the information that is relevant to the audit | Yes |
| h) | the DAA has finished editing the document. | Yes |

Dated Friday, 20 December 2013

## Executive Summary of Audit

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| **General Overview** |
| Summerset in the River City provides hospital and rest home level care for up to 49 residents. On the day of audit there were 18 residents receiving rest home level care rest home (including five residents in serviced apartments) and 20 residents receiving hospital level care.  There is an experienced aged care village manager who has been in the role for three years. He is supported by a nurse manager who has been working at the facility for three months.  The service has addressed seven of eight shortfalls identified at the previous audit. These were around completion of advanced directives, evidence of quality data, internal audits, surveys, meeting minutes, dating and signing documents, restraint risks, evaluation of wounds, completion of orientations and identified aspects of medicine management.  Improvements continue to be required in relation to individualised activity care plans.  This surveillance audit has identified further improvements required around interventions and aspects of medicine documentation. |

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| **Outcome 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. The service has documented complaints and there is evidence of follow up and resolution. The complaints register reviewed included verbal and written complaints. |

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| **Outcome 1.2: Organisational Management** |
| There is a quality and risk management programme and process that have been established and implemented. There is an internal audit schedule, which is completed. Quality data gathered includes the use of comprehensive forms and online data entry. Data is collated monthly and trends identified. Corrective action plans, implementation of plans and resolution occurs when trends are identified. There is discussion of quality data and any identified improvements evidenced at all staff meetings including quality improvement meetings, health and safety/infection control, and registered nurse and caregiver 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 report that staffing levels are sufficient. |

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| **Outcome 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 interventions and management of pain and challenging behaviour. Care plans demonstrate service integration and are individualised. Short-term care plans are used for acute changes in health status. There is a multidisciplinary approach in the evaluation of care plans six monthly. The diversional therapist provides an activities programme for the residents that is varied, interesting and involves the families and community. However there continues to be a requirement to have individualised activity care plans for residents.  Storage, delivery and administration of medications meet medicine management requirements. Staff administering medication have completed medication competency assessments. There are improvements required to ensure all medication charts have a photo identification and allergy status on the chart.  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. |

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| **Outcome 1.4: Safe and Appropriate Environment** |
| The service has a current Warrant of Fitness for the care centre and care apartments, which expires 2 February 2014. There is sufficient space to allow the movement of residents around the facility using mobility aids or lazy boy chairs. There is a preventative maintenance plan in place. All clinical equipment is checked and calibrated annually. |

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| **Outcome 2: Restraint Minimisation and Safe Practice** |
| There is a documented definition of restraint and enablers. 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. 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. There are currently 12 residents using restraint. |

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| **Outcome 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, 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.  Systems in place are appropriate to the size and complexity of the facility |

## Summary of Attainment

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|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 14 | 0 | 3 | 0 | 0 | 0 |
| **Criteria** | 0 | 37 | 0 | 3 | 0 | 0 | 0 |

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|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 33 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 61 |

## Corrective Action Requests (CAR) Report

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | 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 |  |  |  |
| HDS(C)S.2008 | 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 | i) One hospital resident has been commenced on a behaviour log following an incident of verbal aggression. The incident is reported on an incident form. The incident has not been reported in the progress notes. There is no behavioural assessment or plan in place to manage/de-escalate altered behaviour.  ii) One of three hospital resident files sampled is on regular and prn pain relief. There is no initial or on-going pain assessment in place. | Ensure all incidents are documented in progress notes and that all residents with challenging behaviour have appropriate assessments conducted and interventions documented in the care plan to address these. (ii) Ensure residents who experience pain have initial and on-going pain assessments. | 90 |
| HDS(C)S.2008 | 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. | PA Low |  |  |  |
| HDS(C)S.2008 | 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. | PA Low | The activity plan is based around group activities in the programme. There are no individual activity plans in place that take into account individual strengths, interests and preferences. This is a previously identified shortfall that continues to require improvement. | All residents are required to have an individual activity plan. | 90 |
| HDS(C)S.2008 | 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 |  |  |  |
| HDS(C)S.2008 | 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 | Three of 15 medication charts did not have allergies documented and two of 15 charts did not have photo identification. One of 15 charts did not have a photo identification or allergy status documented. | Ensure that all medication charts have photo identification of the resident and that allergies are recorded | 30 |

## Continuous Improvement (CI) Report

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
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# NZS 8134.1:2008: 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 (HDS(C)S.2008:1.1.9)

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Full information is provided at entry to residents and family/representatives. Access to interpreter services is identified in the community and through the Maori Health services. Families are involved in the initial care planning and in on-going care. An information to family newsletter is sent out six monthly that includes an update/review of their relatives care plan and any other significant information. Regular contact is maintained with families as evidenced with a “relative contact” stamp in the progress notes.  ARC D11.3 The information pack is available in large print and advised that this can be read to residents. D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry D16.1b.ii: The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement. This includes 'charging in ORAs-no other benefit for services'. D16.4b: Interviews with four relatives (one hospital and three rest home) all confirmed that they are always informed when their family members health status changes and for any accidents/incidents that occur.  A sample of incidents forms (seven) reviewed from October 2013 identified that for all seven forms family were contacted. The three monthly resident meetings and six monthly relative/friends and advocates meetings include feedback.  The village manager office is based in the care apartments building and the nurse manager is based in the care centre. Both are readily available to residents and families and promote open communication. |

##### Criterion 1.1.9.1 (HDS(C)S.2008:1.1.9.1)

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### Criterion 1.1.9.4 (HDS(C)S.2008:1.1.9.4)

Wherever necessary and reasonably practicable, interpreter services are provided.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### Standard 1.1.10: Informed Consent (HDS(C)S.2008:1.1.10)

Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.

ARC D3.1d; D11.3; D12.2; D13.1 ARHSS D3.1d; D11.3; D12.2; D13.1

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Completed advance directives are in place for five of five resident files sampled (three hospital and two rest home). This is an improvement from the previous audit. |

##### Criterion 1.1.10.7 (HDS(C)S.2008:1.1.10.7)

Advance directives that are made available to service providers are acted on where valid.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### Standard 1.1.13: Complaints Management (HDS(C)S.2008:1.1.13)

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has in place a complaints policy and procedure that aligns with Code 10 of the Code of Rights and is an integral part of the quality and risk management system. The village manager is responsible for ensuring complaints are addressed within the required timeframe and maintains contact with the complainant throughout the complaints process. The nurse manager is involved in any complaints regarding care. Verbal concerns are processed in the same way as written complaints. An electronic and paper based complaints register is maintained and shows investigation of all complaints, dates and actions taken for resolution for the 12 complaints registered. Staff debriefing is offered and training has occurred with Age Concern resulting in greater staff understanding in regards to resident rights of sexuality and intimacy. All staff attended a Code of Rights in-service in September 2013. Complaints, outcomes and improvements are discussed at management and quality meetings (fortnightly), registered nurse meetings (monthly) and caregiver meetings (weekly).  Interviews with four relatives and three residents confirmed that they were well informed around the complaint process.  D13.3h. a complaints procedure is provided to residents within the information pack at entry. |

##### Criterion 1.1.13.1 (HDS(C)S.2008:1.1.13.1)

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### Criterion 1.1.13.3 (HDS(C)S.2008:1.1.13.3)

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

## 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 (HDS(C)S.2008:1.2.1)

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Summerset’s overall vision is "Older New Zealanders should have access to a quality lifestyle in a safe, secure and enjoyable environment at an affordable cost.” The Summerset Group’ board of directors have overall financial and governance responsibility and there is a company strategic business plan in place. Summerset in the River City has a site-specific business plan that is compiled on consultation with the village manager and an operations manager (OM). The plan is separated divided 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 with goals and actions (sighted).  Summerset in the River City provides hospital, medical, rest home level care for up to 49 residents. There are also 12 care apartments certified for rest home level of care. There were 13 rest home residents (including 1 intermediate care) and 20 hospital residents (including 1 intermediate care) in the care centre. There are also five rest home residents in the care apartments building.  The village manager has been with Summerset for eight years and in the current role for three years. A nurse manager (a registered nurse) who has been working at the facility for three months and has previous aged care experience at a senior level supports him. The job description for the nurse manager (sighted) includes responsibilities and accountabilities of the role. Village managers and nurse managers attend annual organisational forums and regional forums six monthly. The nurse manager attends clinical education through the MidCentral District Health Board (DHB).  An operations manager is available to support the facility and staff. Advised by the village manager that the operations manager is available to be contacted by telephone or email as required.  Summersets clinical and quality manager was on site during day one of the audit and advised that Summerset’s clinical educator has supported the nurse manager during her orientation period.  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 nurse manager has attended at least eight hours of professional development activities related to managing a hospital since her recent appointment. An education and training plan is in place. |

##### Criterion 1.2.1.1 (HDS(C)S.2008:1.2.1.1)

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### Criterion 1.2.1.3 (HDS(C)S.2008:1.2.1.3)

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### Standard 1.2.3: Quality And Risk Management Systems (HDS(C)S.2008:1.2.3)

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Summerset in River City 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 and a set agenda item for the quality meeting, health and safety, infection control, RN registered nurse and caregiver meetings.  The village manager’s’ report covers staffing, business and risk plan progress, financial, village occupancy, audits (external), complaints and compliments, survey results and resident meetings. The nurse manager provides a clinical report to the village manager at the quality meetings.  Policies and procedures are developed at organisational level. The policies and procedures and associated implementation systems provide a good level of assurance that it Summerset in the River City 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. There is with a master copy 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 that are based on their policies. Discussion regarding policy development/revision occurs at staff meetings. Release of updated or new policy occurs across the organisation (sighted). The release of a policy coincides with an audit and staff education. 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. The quality improvement meeting is chaired by the village manager and attended by the Summerset property manager, nurse manager, office manager, diversional therapist and infection control officer and health and safety representatives as required. 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. The village manager reports to the regional operations manager and Summerset’s 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 health and safety meeting (which includes infection control), restraint meeting, quality improvement meetings, registered nurse and RN and staff meetings. The nurse manager meets with laundry staff two monthly. The village manager meets with the external food services provider chef monthly and food services audit outcomes and quality risk management is are discussed and minuted. 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 the benchmarking across the organisation. The health and safety and infection control committee meets monthly and attend the quality meetings as required. Health and safety and infection control is also an agenda item at all staff meetings. Health and safety and incident/accidents, internal audits are completed. Annual analysis of results is completed and provided across the organisation. Ten staff interviewed (across services and variety of shifts) confirmed they are aware of the results of internal audits, health and safety and infection control data, trends and corrective actions, and new or reviewed policies and procedures.  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. For example an audit on the completion of accident/incident forms (October 2013) identified an area for improvement. Staff training was completed and a follow up audit is to be conducted in November 2013. Audit outcomes and corrective actions are linked to meeting minutes. This is an improvement from the previous audit. Issues are reported to the appropriate committee e.g. quality. Summerset’s 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 (sighted) 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 staff survey completed in October 2013 were discussed at QI the quality meeting. The resident and family satisfaction survey is in progress.  D19.3: There is a comprehensive health and safety and risk management programme in place. The village manager and nurse manager are health and safety officers.  The risk management plan has been reviewed at the quality meeting in July and November 2013 (meeting minutes sighted). There is a current hazard register.  D19.2g Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. Strategies and equipment available to minimise falls risk are, floor sensor mats, nurse call bells and mobility aids. |

##### Criterion 1.2.3.1 (HDS(C)S.2008:1.2.3.1)

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### Criterion 1.2.3.3 (HDS(C)S.2008:1.2.3.3)

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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### Criterion 1.2.3.4 (HDS(C)S.2008:1.2.3.4)

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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### Criterion 1.2.3.5 (HDS(C)S.2008:1.2.3.5)

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### Criterion 1.2.3.6 (HDS(C)S.2008:1.2.3.6)

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### Criterion 1.2.3.7 (HDS(C)S.2008:1.2.3.7)

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### Criterion 1.2.3.8 (HDS(C)S.2008:1.2.3.8)

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### Criterion 1.2.3.9 (HDS(C)S.2008:1.2.3.9)

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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### Standard 1.2.4: Adverse Event Reporting (HDS(C)S.2008:1.2.4)

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| 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 quality improvement meetings, health and safety meetings, staff and registered nurse meetings including actions to minimise recurrence.  D 19.c: 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 four family members interviewed stated they are informed of changes in health status and incidents/accidents. Seven incident reports for October 2013 were reviewed. The October 2013 monthly incident/accident analysis form observed shows 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 seven incidents/accidents sampled for the month of October 2013. Two accident/forms were incomplete. The nurse manager advised that this had been identified by the service and corrective actions have been implemented to rectify this including training of staff and a follow up internal audit. There is RN follow up and review of incident. Seven incidents were traced back to the care plans and progress notes of respective residents. Six of seven care plans and progress notes reflected the incident and documented registered nurse assessment any emergent treatment given, preventative measures to be implemented (where appropriate) and contact with family/whanau. One incident of resident aggression was not recorded in the progress notes and there was no documentation to guide staff for the management of difficult behaviour (link CAR 1.3.6.1) One registered nurse and nurse manager interviewed advised that staff are in regular contact with family and this is evidenced by review of entries in the progress notes identified by a “relative contact” stamp. 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 (HDS(C)S.2008:1.2.4.2)

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### Criterion 1.2.4.3 (HDS(C)S.2008:1.2.4.3)

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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### Standard 1.2.7: Human Resource Management (HDS(C)S.2008:1.2.7)

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The recruitment and staff selection process requires that relevant checks, including police checks be completed to validate the individual’s application, qualifications and experience. A copy of practising certificates including the registered nurse and general practitioners is kept (sighted). There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development.  Five staff files were reviewed (nurse manager, one registered nurse, one recently employed caregiver, one enrolled nurse and one cleaner). All recruitment documentation is kept online. Reference checks are completed before employment is offered. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. There is a three-week orientation followed by a meeting to assess individual progress. All orientations have been completed within the three-week timeframe. This is an improvement from the previous audit. There is a three-month performance review and orientation evaluation. Seven caregivers and one enrolled nurse interviewed are able to describe the orientation process and believed new staff were adequately orientated to the service. One caregiver interviewed has just completed an orientation and feels well supported in her new role. One enrolled nurse has completed the enrolled nurse transition and awaiting her practicing certificate. The enrolled nurse will then begin the registered nurse orientation programme.  Discussion with the nurse manager confirms there is a comprehensive in-service training programme in place that is generated by the company however; the programme can be amended to meet the facility requirements. The programme 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 seminars and sessions provided by Summerset and the local DHB. Two nurses are attending education at the MidCentral DHB on the day of audit. Education provided in 2013 includes: code of rights, manual handling, medication, nutrition and hydration, incontinence, pain and symptom management, restraint minimisation, challenging behaviour, privacy and dignity, infection control. Training occurs at least monthly and records include date, session topic, and names of attendees. The service has identified that attendance could be improved and has now commenced a process of sending reminder notices out to staff. 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. Caregivers (with the exception of orientating staff) either have achieved national certificate in the support of the older person or have commenced Career Force training which is delivered weekly on site.  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, and syringe driver. |

##### Criterion 1.2.7.2 (HDS(C)S.2008:1.2.7.2)

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### Criterion 1.2.7.3 (HDS(C)S.2008:1.2.7.3)

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### Criterion 1.2.7.4 (HDS(C)S.2008:1.2.7.4)

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### Criterion 1.2.7.5 (HDS(C)S.2008:1.2.7.5)

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### Standard 1.2.8: Service Provider Availability (HDS(C)S.2008:1.2.8)

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Sufficient staff are rostered on duty to manage the care requirements of the rest home and hospital residents at the care centre and care apartments. 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 emergency issues or clinical support. The registered nurses (RNs) are asked to contact RNs in other Summerset facilities after hours for clinical advice. The service provides 24-hour RN cover. There is 24-hour caregiver on at the care apartments. The RN makes contact at least three times during the night shift and at handover in the morning. Rosters evidence that extra staff can be called on for increased resident requirements. Interviews with seven caregivers, three residents and four families identify that staffing is adequate to meet the needs of residents. The determining staffing levels and skills mix policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery. This defines staffing ratios to residents. Rosters implement the staffing rationale. |

##### Criterion 1.2.8.1 (HDS(C)S.2008:1.2.8.1)

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

## 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 (HDS(C)S.2008:1.3.3)

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| D.16.2, 3, 4: The five resident files sampled (three hospital and two rest home) identified that the registered nurses 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 five files sampled identified that the long-term support plan is developed within three weeks. All five long-term care plans sampled are signed and dated by the registered nurse. This is an improvement from the previous audit.  There is documented evidence of multidisciplinary reviews held six monthly involving the resident/family/whanau, registered nurse, nurse manager, restraints co-ordinator, diversional therapist, care staff, medical (including medication review) and where applicable allied health input. The registered nurses amend the long-term support plan to reflect on-going 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 and podiatrist. Allied health notes are maintained in the residents file. All five resident files sampled documented discussions with family/whanau regarding changes to health, incidents, infections, MDT meetings, and GP visits. D16.5e: Four of four five resident files sampled identified that the GP had seen the resident within two working days of admission. One resident had been seen by the GP prior to transfer from the village to the rest home. 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. All five resident files sampled identified integration of allied health professionals and a team approach.  The service has a contracted GP who visits weekly and at any other time for acute events. The residents may choose to retain their own GP. The contracted GP practices within a local GP group practice. The local GP’s provide cover for the GP leave. The nurse manager (interviewed) stated the staff use a fax system for routine requests and phone call to the GP for more urgent requests. The RNs receive a fax response (sighted). The GP is available weekends. RNs can initiate an ambulance referral to the emergency department if necessary. RNs refer residents to nursing specialists as required and notify the GP. The GP send referrals for consultants and medical specialists. The GP was not available for interview. There is a verbal handover at the beginning of each shift to the caregivers to ensure staff are kept informed of resident’s health status and any significant events. Seven caregivers and one enrolled nurse interviewed state the communication system is very good and they receive relevant information at handover to deliver safe and timely cares for the residents.  Tracer methodology: hospital level resident:  XXXXXX *This information has been deleted as it is specific to the health care of a resident.*  Tracer methodology: rest home resident:  XXXXXX *This information has been deleted as it is specific to the health care of a resident.* |

##### Criterion 1.3.3.1 (HDS(C)S.2008:1.3.3.1)

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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### Criterion 1.3.3.3 (HDS(C)S.2008:1.3.3.3)

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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### Criterion 1.3.3.4 (HDS(C)S.2008:1.3.3.4)

The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### Standard 1.3.6: Service Delivery/Interventions (HDS(C)S.2008:1.3.6)

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| 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 seven caregivers and one enrolled nurse and one registered nurse 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, transfer belts, resident mobility aids, wheelchairs, gloves, aprons and masks. i) One hospital resident has been commenced on a behaviour log following an incident of verbal aggression. The incident is reported on an incident form. The incident has not been reported in the progress notes. There is no behavioural assessment or plan in place to manage/de-escalate altered behaviour. One of three hospital resident files sampled is on regular and prn pain relief. There is no initial or on-going pain assessment in place. These are areas requiring improvement. D18.3 Dressing supplies are available and adequate supplies of wound care products, blood glucose monitoring equipment and other medical equipment is sighted. There are adequate supplies of incontinent products in all areas.  Wound assessment and treatment/management plans are in place for four minor wounds, one chronic wound and six skin tears. There are no pressure areas. All wounds have an initial wound assessment and on-going wound assessments with each dressing change. Dressing types and evaluations are documented on the on-going wound assessment treatment form. There are detailed evaluations and healing progress documented in the progress notes. Short-term care plans are in place for skin tears. The chronic wound is linked to the long-term care plan.  Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day and night use. Specialist continence advice is available as needed and the nurse manager could describe the referral process.  All falls are reported on the resident accident/incident form. Coombes falls risk assessments and mobility scale 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 monthly. Chair scales are available and have been calibrated. MUST nutritional screening is completed for residents identified with weight loss. Interventions include; encouragement and assistance with meals more frequent weighing, food and fluid monitoring, dietary supplements and GP notification. The dietitian is involved as required.  Restraint use for two hospital residents files sampled and associated risks are linked to the long-term care plan. This is an improvement since the previous audit. |

##### Criterion 1.3.6.1 (HDS(C)S.2008:1.3.6.1)

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| When a resident's condition alters, the registered nurses initiate a review and if required, GP or specialist consultation.  i) A behaviour log has been commenced for one hospital resident with altered behaviour.  ii) Pain assessments are in place for two out of two rest home residents on prn pain relief. There is monitoring of the effectiveness of prn pain relief is recorded in the progress notes. Two of three hospital resident files did not identify pain as a problem. |
| **Finding:** |
| i) One hospital resident has been commenced on a behaviour log following an incident of verbal aggression. The incident is reported on an incident form. The incident has not been reported in the progress notes. There is no behavioural assessment or plan in place to manage/de-escalate altered behaviour.  ii) One of three hospital resident files sampled is on regular and prn pain relief. There is no initial or on-going pain assessment in place. |
| **Corrective Action:** |
| Ensure all incidents are documented in progress notes and that all residents with challenging behaviour have appropriate assessments conducted and interventions documented in the care plan to address these. (ii) Ensure residents who experience pain have initial and on-going pain assessments. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### Standard 1.3.7: Planned Activities (HDS(C)S.2008:1.3.7)

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| There is a qualified diversional therapist (DT) employed for 30 hours a week to implement the activity programme for the rest home and hospital residents. The care apartment residents join in the activities at the care centre. The programme is planned for a month and all residents receive a copy of the programme that is also displayed on noticeboards throughout the facility. There are spacious areas where recreational activities take place. Group activities include (but are not limited to); newspaper reading, word games, exercise, floor games, bingo, card games, memory games, happy hour. There is weekly musical entertainment. Guest speakers visit the home such as bird rescue, museum staff and Age Concern. Residents enjoy inter-home visits and visiting pet day, weekly. One on one time is spent with hospital residents who are unable to participate in group activities and for residents who do not wish to join in-group activities. Families are invited to the resident meetings and afternoon teas. Festive occasions, birthdays and event days are celebrated such as Queens Birthday, Labour day and International day of the Older Person. There are outings weekly. There is a volunteer driver available. The DT has a current first aid certificate. There is a Christian service schedule with church services on-site weekly. The DT is able to take communion on Sundays and also represents Summerset at resident funerals.  The DT is a member of the DT support group and maintains her professional development in regards to the role. The DT reports monthly to the nurse manager. The DT attends clinical reviews of resident care plans. The activity plan is based around group activities in the programme. There are no individual activity plans in place that take into account individual strengths, interests and preferences. This previously identified shortfall continues to require improvement. |

##### Criterion 1.3.7.1 (HDS(C)S.2008:1.3.7.1)

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| A DT needs assessment is completed for all new residents. Cultural and spiritual needs are included in the registered nurse initial assessment and long-term care plan. The DT maintains individual resident progress notes and attendance sheet. |
| **Finding:** |
| The activity plan is based around group activities in the programme. There are no individual activity plans in place that take into account individual strengths, interests and preferences. This is a previously identified shortfall that continues to require improvement. |
| **Corrective Action:** |
| All residents are required to have an individual activity plan. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### Standard 1.3.8: Evaluation (HDS(C)S.2008:1.3.8)

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The long-term care plan is evaluated at least every six months or earlier for any changes to resident’s health status. Short-term care plans are reviewed regularly with short-term needs resolved or if an on-going problem is added to the long-term care plan. Families are invited by letter to attend the care plan review and are notified of changes if unable to attend. Discussions with families regarding care plans are evidenced in the resident; progress notes by a "relative contact" stamp. Risk assessment tools are reviewed six monthly or earlier if increased risk such as falls or pressure area risk. The GP completes three monthly reviews of the medication charts. |

##### Criterion 1.3.8.2 (HDS(C)S.2008:1.3.8.2)

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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### Criterion 1.3.8.3 (HDS(C)S.2008:1.3.8.3)

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### Standard 1.3.12: Medicine Management (HDS(C)S.2008:1.3.12)

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The service uses individualised medication blister packs. The medications are delivered monthly and checked in by the registered nurse (RN) and a senior competent medication caregiver. A medication reconciliation form is completed. Medication requests/medication charts are faxed to the supplying pharmacy and these are delivered by courier system. The medication trolleys (two) are kept in the locked medication room in the care centre. The care apartments has a locked trolley kept in the nurses’ station. Registered nurses, enrolled nurses and senior caregivers undergo a medication competency, theory and practical prior to deemed competent to administer medications. Annual medication training is attended. 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. A pharmacy audit is completed six monthly. Current standing orders are in place and meet medication requirements. The medication fridge is monitored daily. All eye drops in use on the trolleys are dated on opening. This is an improvement from the previous audit. Medication signing sheets are all correct with no gaps. This is an improvement from the previous audit. There are no self-medicating residents. Medication charts record prescribed medications by residents’ general practitioner, including PRN and short course medications. All prescribed medications on the 10 medication charts are signed by the GP. This is an improvement from the previous audit. Two of 10 medication charts did not have an allergy documented or photo identification therefore the sample was extended to 15 charts to eliminate a trend. Three of 15 medication charts did not have allergies documented and two of 15 charts did not have photo identification. One of 15 charts did not have a photo identification or allergy status documented. This is an area requiring improvement. Medications are reviewed three monthly by the GP. 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; 13 Thirteen medication charts reviewed identified that the GP had seen the reviewed the resident three monthly. Two medication charts had been recharted and are not due for review. |

##### Criterion 1.3.12.1 (HDS(C)S.2008:1.3.12.1)

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.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| All prescribed medications on the 15 medication charts are signed by the GP. This is an improvement from the previous audit. Eight of 15 medication charts had an allergy documented and photo identification.  Three of 15 medication charts did not have allergies documented and two of 15 charts did not have photo identification. One of 15 charts did not have a photo identification or allergy status documented. |
| **Finding:** |
| Three of 15 medication charts did not have allergies documented and two of 15 charts did not have photo identification. One of 15 charts did not have a photo identification or allergy status documented. |
| **Corrective Action:** |
| Ensure that all medication charts have photo identification of the resident and that allergies are recorded |
| **Timeframe (days):** 30 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### Criterion 1.3.12.3 (HDS(C)S.2008:1.3.12.3)

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### Criterion 1.3.12.5 (HDS(C)S.2008:1.3.12.5)

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### Criterion 1.3.12.6 (HDS(C)S.2008:1.3.12.6)

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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### Standard 1.3.13: Nutrition, Safe Food, And Fluid Management (HDS(C)S.2008:1.3.13)

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Food services at Summerset is are contracted to an external catering company and all foods is cooked on site. The chef/kitchen manager oversees the food service. There is one chef and one catering assistant on duty each day in the care centre kitchen and a café supervisor on duty at the care apartments. The eight week seasonal menu is reviewed six monthly and menu changes due to resident preferences can be made at that time The 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. The chef receives a dietary requirement form with every new admission and when there are dietary reviews or changes. Regular monitoring of resident's weight and nutritional needs occur. The company dietitian reviews the menu and approves the recipes. Each menu week has allergen allergy declaration cards. Dietary needs are catered for and alternative choices are offered for dislikes. Meals are transported to the dining room and care apartments in hot boxes. End point cooking temperatures are checked twice daily. Fridge and freezer temperatures are monitored daily. Dishwasher wash and rinse temperatures are checked twice daily. All foods are stored in sealed, labelled containers and off the floor in the pantry. All foods are dated in the refrigerator. Cleaning schedules are completed and signed. The first aid kit is checked monthly.  Residents and family interviewed report satisfaction with the food service provided.  D19.2 Staff have been trained in safe food handling. |

##### Criterion 1.3.13.1 (HDS(C)S.2008:1.3.13.1)

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### Criterion 1.3.13.2 (HDS(C)S.2008:1.3.13.2)

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### Criterion 1.3.13.5 (HDS(C)S.2008:1.3.13.5)

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

## 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.

#### Standard 1.4.2: Facility Specifications (HDS(C)S.2008:1.4.2)

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The care centre and care apartment buildings have a current Warrant of Fitness, which expires on 2 February 2014. Preventative maintenance is carried out. Hot water temperatures are monitored three monthly and records sighted show they are within a safe range. All clinical equipment has been calibrated annually. Hoists and electric beds have been serviced annually. Electrical equipment has been tested annually. 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 (HDS(C)S.2008:1.4.2.1)

All buildings, plant, and equipment comply with legislation.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

# NZS 8134.2:2008: Health and Disability Services (Restraint Minimisation and Safe Practice) Standards

## Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

#### Standard 2.1.1: Restraint minimisation (HDS(RMSP)S.2008:2.1.1)

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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| **Attainment and Risk:** FA |
| **Evidence:** |
| 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 is currently under review by the clinical and quality manager. A draft form dated November 2013 was sighted. 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 bedrails as an enabler. The service currently has 12 residents assessed as requiring a restraint (bedrails/lap belt). There are clear guidelines in the policy to determine what a restraint is and what an enabler is. The use of enablers is linked to the care plan for the four residents with an enabler. Risks for the use of an enabler is also documented in the care plan. 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 (HDS(RMSP)S.2008:2.1.1.4)

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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

# NZS 8134.3:2008: Health and Disability Services (Infection Prevention and Control) Standards

#### Standard 3.5: Surveillance **(**HDS(IPC)S.2008:3.5)

Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.

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| **Attainment and Risk:** FA |
| **Evidence:** |
| 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 infection control committee. The committee is newly formed and includes a cleaner, laundry person, diversional therapist and two caregivers (one from care apartments). Infection control data is discussed at the infection control committee and a report forwarded to the nurse manager. Infection rates, trends and improvements are discussed at the weekly caregiver meetings. The infection control programme is linked with the quality management programme.    The infection control data entered on line is reviewed by the Summerset clinical quality manager monthly, 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. The facility benchmarks 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. |

##### Criterion 3.5.1 (HDS(IPC)S.2008:3.5.1)

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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### Criterion 3.5.7 (HDS(IPC)S.2008:3.5.7)

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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
|  |
| **Corrective Action:** |
|  |
| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |