# Summerset Care Limited - Summerset At Bishopscourt

## Introduction

This report records the results of a Certification Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Summerset Care Limited

**Premises audited:** Summerset At Bishopscourt

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

**Dates of audit:** Start date: 5 March 2015 End date: 6 March 2015

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 44

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

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

## General overview of the audit

Summerset at Bishopscourt is part of the Summerset group and opened in May 2014. The facility is certified to provide hospital (geriatric and medical), rest home level care for up to 41 residents in the care centre and 20 rest home residents in the serviced apartments. On the day of the audit there were 44 residents. The village manager and nurse manager are well qualified for their roles. There are systems and policies that are in the process of being implemented to guide care for residents. An orientation programme and in-service training programme is in place that provides staff with appropriate knowledge and skills to deliver care. This audit has identified improvements required around aspects of the quality programme, aspects of care planning, aspects of the activity programme, aspects of medication, aspects of restraint and aspects of the infection control programme.

## Consumer rights

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Standards applicable to this service fully attained. |

Summerset at Bishopscourt provides care in a way that focuses on the individual resident. There is a Maori health plan and cultural safety policy supporting practice. Cultural assessment is undertaken on admission and during the review processes. Policies are implemented to support individual rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. The service functions in a way that complies with the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and related services is readily available to residents and families. Policies are available that support residents’ rights. Care plans accommodate the choices of residents and/or their family. Complaints processes are being implemented and complaints and concerns are managed and documented. Residents and family interviewed verified on-going involvement with community.

## Organisational management

|  |  |  |
| --- | --- | --- |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of low risk. |

Key components of the quality management system link to a number of meetings including monthly quality meetings. Resident meetings have commenced. Quality performance is reported to staff at meetings and includes discussion about incidents, infections and internal audit results. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care. There is a staffing policy being implemented.

## Continuum of service delivery

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

The service has assessment processes and residents needs are assessed prior to entry. There is a well-developed information pack available for residents and families/whānau at entry. Assessments, resident centred care plans and evaluations are completed by the registered nurse. Risk assessment tools and monitoring forms are available and implemented. Resident centred care plans were individualised. A diversional therapist and recreation assistant plan and implement an integrated activity programme. There are outings into the community and visiting entertainers. There is medication system that meets legislative requirements. Staff responsible for the administration of medications complete annual medication competencies and education. The general practitioner reviews the medication charts three monthly. The food service is contracted to an external contract company. Resident's individual dietary needs were identified and accommodated. Staff have attended food safety and hygiene training. The menu is designed by a dietitian at organisational level. Individual and special dietary needs were catered for. Alternative options were provided. Residents interviewed responded favourably to the meals provided.

## Safe and appropriate environment

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

There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances. Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. Documented systems are in place for essential, emergency and security services.

The building has a current certificate of public use. There is a preventative and planned maintenance schedule in place. Chemicals are stored safely throughout the facility. All bedrooms are spacious and all but six have ensuites, there are large shared bathrooms for the residents without ensuite facilities. There is sufficient space to allow the movement of residents around the facility. The hallways and communal areas are spacious and accessible. The outdoor areas are safe and easily accessible with appropriate seating and shaded areas. Housekeeping staff maintain a clean and tidy environment. All laundry and linen is completed on-site.

## Restraint minimisation and safe practice

|  |  |  |
| --- | --- | --- |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

There are documented policies and procedures around restraint use and use of enablers. Currently there are three residents using restraint and one with an enabler. Staff training around the use of restraint and enablers is provided and staff interviewed understand the philosophy of minimal use. The use of restraint and enablers is reported to the monthly quality meeting. There is a restraint co-ordinator and restraint approval group that will meet three monthly.

## Infection prevention and control

|  |  |  |
| --- | --- | --- |
| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | Some standards applicable to this service partially attained and of low risk. |

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. There is an infection control coordinator (registered nurse). There are a suite of infection control policies, standards and guidelines to support practice. Appropriate training of staff is included as part of the programme. Surveillance activities include audits of the facility, hand hygiene and surveillance of infection control events and infections. Staff receive on-going training in infection control.

## Summary of attainment

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 39 | 0 | 5 | 6 | 0 | 0 |
| **Criteria** | 0 | 87 | 0 | 8 | 6 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | Discussions with staff (five caregivers, four registered nurses, one property manager/maintenance, one chef and one housekeeper) confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers’ Rights (the Code). Nine residents (six rest home and three hospital) and four relatives (one rest home and three hospital) were interviewed and confirmed the services being provided are in line with the Code. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Informed consent and advanced directives were recorded as evidenced in the seven resident files reviewed. Advised by staff that family involvement occurs with the consent of the resident. Residents interviewed confirmed that information was provided to enable informed choices and that they were able to decline or withdraw their consent. Resident admission agreements were signed. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Residents are provided with a copy of the Code on entry to the service. Residents interviewed confirmed they were aware of their right to access independent advocacy services and advocacy pamphlets are available at reception. Discussions with relatives confirmed the service provides opportunities for the family/enduring power of attorney (EPOA) to be involved in decisions. The resident files include information on residents’ family/whanau and chosen social networks. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. Activities programmes includes opportunities to attend events outside of the facility including activities of daily living, for example, shopping. Interview with staff, residents and relatives informed residents are supported and encouraged to remain involved in the community and external groups (# link 1.3.7.1). Relative and friends are encouraged to be involved with the service and care. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The organisational complaints policy stated that the village manager had overall responsible for ensuring all complaints (verbal or written) were fully documented and investigated. There is a complaints register that includes relevant information regarding the complaint. Documentation included follow up letters and resolution were available. The number of complaints received each month is reported monthly to staff via the various meetings. There were three complaints received in 2014 and two complaints in 2015. All complaints were fully documented with follow up letters and resolution. Discussion with residents and relatives confirmed they were provided with information on the complaints process. Feedback forms are available for residents/relatives in various places around the facility. A complaints procedure is provided to residents within the information pack at entry. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | The service provides information to residents that include the Code, complaints and advocacy. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Residents and relatives interviewed identified they are well-informed about the code of rights. Resident meetings provide the opportunity to raise concerns. An annual residents/relatives survey is due for completion in 2015. Advocacy and code of rights information is included in the information pack and are available at reception. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | Staff interviewed were able to describe the procedures for maintaining confidentiality of resident records, resident’s privacy and dignity. House rules and a code of conduct are signed by staff at commencement of employment. Church services are held two weekly and resident files include cultural and spiritual values. Contact details of spiritual/religious advisors are available to staff and a Catholic priest is available at any time for the service including room blessings. Residents and relatives interviewed reported that residents are able to choose to engage in activities and access community resources. There is an elder abuse and neglect policy and staff education and training on abuse and neglect has been provided. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | Summerset has a Maori health plan that includes a description of how they achieve the requirements set out in the contract. There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. Family/whanau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with disability and other community representative groups as requested by the resident/family. Cultural needs are addressed in the care plan. At the time of audit the staff reported there were no residents that identify as Maori. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | An initial care planning meeting is carried out where the resident and/or whanau as appropriate/able are invited to be involved. Individual beliefs or values are further discussed and incorporated into the care plan. Six monthly multi-disciplinary team meetings occur to assess if needs are being met. Family are invited to attend. Discussion with relatives confirms values and beliefs are considered. Residents interviewed confirm that staff take into account their culture and values. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Staff job descriptions include responsibilities and staff sign a copy on employment. The full facility meetings occur monthly and include discussions on professional boundaries and concerns as they arise. Management provide guidelines and mentoring for specific situations. Interviews with the village manager, nurse manager and registered nurses confirmed an awareness of professional boundaries. Care assistants discussed professional boundaries in respect of gifts. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | Residents and relatives interviewed spoke very positively about the care and support provided. Staff have a sound understanding of principles of aged care and state that they feel supported by the village manager and nurse manager.  Summerset has a suite of appropriate policies and procedures that are updated as necessary. There is a quality improvement programme that includes performance monitoring against clinical indicators and benchmarking against like services within the group is undertaken. There is a culture of on-going staff development with an in-service programme being implemented. There is evidence of education being supported outside of the training plan. Services are provided at Summerset that adhere to the health & disability services standards and all approved service standards are adhered to. There are implemented competencies for caregivers and registered nurses including but not limited to: insulin administration, medication, wound care and manual handling. Registered nurses have access to external training. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents and family members interviewed stated they are informed of changes in health status and incidents/accidents. Residents and family members also stated they were welcomed on entry and were given time and explanation about services and procedures. Resident/relative meetings have commenced and will continue monthly with a health and disability advocate present at the meeting every three months. The village manager and the nurse manager have an open-door policy. The service has commenced a newsletter (February 2015) for residents and relatives. Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The service has policies and procedures available for access to interpreter services for residents (and their family/whānau). If residents or family/whanau have difficulty with written or spoken English the interpreter services are made available. All resident were English speaking on the day of the audit. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Summersets overall vision is “to be the first choice provider of retirement village and aged care services in New Zealand.” The service provides care for up to 62 residents at hospital (geriatric and medical) and rest home level care. On the day of the audit, there were 44 residents in total, 23 residents at rest home level (three are in the service apartments and includes one respite) and 21 residents at hospital level including one receiving palliative care. The Summerset Group Limited Board of Directors have overall financial and governance responsibility and there is a company strategic business plan in place. Summerset at Bishopscourt has a site specific business plan and goals that is developed in consultation with the village manager, nurse manager and regional operations manager (ROM).  The Summerset at Bishopscourt quality plan is reviewed regularly throughout the year. There is a full evaluation at the end of the year. The 2014 evaluation was sighted. The village manager (non-clinical) has been in the current role at Summerset for two years and has attended at least eight hours of leadership professional development relevant to the role. The village manager is supported by a nurse manager. The nurse manager has been in the role for six months and has a considerable background in nursing and health management with a master’s degree in nursing and a post graduate diploma in professional supervision.  Village managers and nurse managers attend annual organisational forums and regional forums over two days. The nurse manager attends clinical education, forums/provider meetings at the local DHB. There is a regional operations manager who is available to support the facility and staff.  Policies and procedures are developed at an organisational level with input from staff and external specialist expertise where required. An education and training plan is in place 2015. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | During a temporary absence, the nurse manager will cover the manager’s role. The regional manager and the clinical and quality manager provide oversight and support. The audit confirmed the service has operational management strategies and a quality improvement programme to minimise risk of unwanted events. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | Summerset at Bishopscourt is implementing the organisation’s quality and risk management system. There are policies and procedures being implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed on a regular basis. The content of policy and procedures are detailed to allow effective implementation by staff.  The Summerset group has a ‘clinical audit, training and compliance’ calendar. The calendar schedules the training and audit requirements for the month and the village manager completes a ‘best practice’ sheet confirming completion of requirements. The best practice sheet includes reporting including (but not limited to): meetings held, induction/orientation, audits, competencies, projects. The best practice sheet is sent to head office as part of the on-going monitoring programme.  There is a meeting schedule that is being established at the service including a monthly quality meeting that includes discussion about clinical indicators (e.g. incident trends, infection rates) registered nurse meetings, health and safety three monthly, infection control meeting (first one January 2015) and restraint meeting (first one January 2015). There are other meetings being held such as care staff, kitchen and activities. Meeting minutes do not always include the person responsible for actions noted, timeframes and sign off when completed.  Resident/family meetings have recently been established – first meeting September 2014 and a more recent meeting held in February 2015. An annual residents/relatives survey is due to be completed in 2015. Meal satisfaction surveys have been undertaken.  Summerset at Bishops court is implementing an internal audit programme that includes aspects of clinical care. Issues arising from internal audits are not always developed into a corrective action plans. Monthly and annual analysis of results is completed and provided across the organisation however the service has not yet been open for a full year. 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 (# link 3.5.7). Health and safety internal audits are completed. Summersets clinical and quality manager analyses data collected via the monthly reports and corrective actions are required based on benchmarking outcomes. Summerset has a data tool "Sway”. Sway is integrated and accommodates the data entered. There is a health and safety and risk management programme in place including policies to guide practice. The property manager/maintenance is the health and safety representative (interviewed). 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. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | Incident and accident data has been collected and analysed. Discussions with the service confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. A sample of resident related incident reports for February 2015 were reviewed. All reports and corresponding resident files reviewed evidence that appropriate clinical care has been provided following an incident. The incident reporting policy includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Data was linked to the organisation's benchmarking programme and used for comparative purposes. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | There are human resources policies to support recruitment practices. A list of practising certificates is maintained. Seven staff files were reviewed and all had relevant documentation relating to employment. Performance appraisals are not due to be completed. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme includes documented competencies and induction checklists (sighted in files of newly appointed staff). Staff interviewed were able to describe the orientation process and believed new staff were adequately orientated to the service. There is an annual education plan that is outlined on the ‘clinical audit, training and compliance calendar’. This includes all required education as part of these standards. The plan is being implemented. A competency programme is in place with different requirements according to work type (e.g. caregiver, registered nurse, and kitchen). Core competencies are completed and a record of completion is maintained on staff files and well as being scanned into ‘sway’. Staff interviewed were aware of the requirement to complete competency training. Summerset organisation employs a clinical education manager who is a registered nurse with a current practising certificate. The clinical education manager facilitates the orientation programme for new staff and support the on-going education programme. Caregivers complete an aged care programme. There are 24 caregivers employed currently, 15 have a qualification and nine are enrolled in an aged care programme. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The village manager and nurse manager work 40 hours per week Monday to Friday and are available on call for any emergency issues or clinical support. The service provides 24 hour RN cover with a minimum of three caregivers on duty. One caregiver is allocated to the care apartments on morning shifts, afternoon shifts and night shifts. A staff availability list ensures that staff sickness and vacant shifts are filled. Caregivers interviewed confirmed that staff are replaced. Staffing levels and skills mix policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery. There is always a staff member with a current first aid certificate and medication competency on each shift. The service is actively recruiting to ensure a safe service to residents as resident numbers/acuity increase. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident files reviewed were appropriate to the service type. Residents entering the service have all relevant initial information recorded on admission into the resident’s individual record. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files were protected from unauthorised access by being held in a locked cupboard. Rest home residents residing in the service apartments have their records kept in a locked cupboard within the serviced apartment area. Progress notes for rest home residents residing in the serviced apartments are completed by staff whilst remaining on the service apartment floor in a private area to ensure privacy is maintained. Care plans and notes were legible and where necessary signed (and dated) by a registered nurse. Entries are legible, dated and signed by the relevant care assistant or registered nurse including designation. Individual resident files demonstrate service integration. There was an allied health section that contained general practitioner notes and the notes of allied health professionals and specialists involved in the care of the resident. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | Residents are assessed prior to entry to the service by the needs assessment team, and an initial assessment was completed on admission. The nurse manager screens all potential enquiries to ensure the service can meet the required level of care and specific needs of the resident. The service has specific information available for residents/families/whānau at entry and it included associated information such as the Health and Disability Code of Rights, advocacy and complaints procedure. The admission agreement reviewed aligned with the ARC contract and exclusions from the service were included in the admission agreement. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | There is an exit discharge and transfer policy that describes guidelines for death, discharge, transfer, documentation and follow up. This directs staff to the appropriate documentation. All relevant information is documented and communicated to the receiving health provider or service. Follow up occurs to check that the resident is settled or, in the case of death, communication with the family is made. |
| 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 Moderate | The service medication management system follows recognised standards and guidelines for safe medicine management practice in accordance with the Medicines Care Guide for Residential Aged Care 2011. RNs are responsible for the administration of medications in the rest home and hospital wings. Medication competencies and education have been completed. All medications are checked on delivery with any discrepancies fed back to the supplying pharmacy. At the time of audit there was one respite resident who was self-administering medication, but had no medication chart, or self-medication competency. Medication administration by staff was observed to be compliant. Medication signing sheets were correctly signed for regular and as required medications.  Fourteen resident medication charts sampled (six rest home and eight hospital) were identified with photographs and allergy status. The prescribing of regular and prn medications meets legislative requirements. Twelve of 14 medication charts reviewed identified that the GP had reviewed the medication chart three monthly (one new admission and one respite). |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | An external company is contracted for the provision of meals on-site. There is a four week rotating menu approved by the dietitian. There are alternative meal options available and resident likes/dislikes and preferences are known and accommodated. Special diets include diabetic and pureed meals as assessed for residents by the RN. The cook receives a dietary profile for each resident.  The kitchen has large equipment items all purchased within the last year. Other items have been tested and tagged. The fridge, freezer and dishwasher have daily temperatures recorded. End cooked food temperatures are recorded daily. Cleaning schedules are maintained. Chemicals are stored safely within the kitchen which is locked after hours. Staff were observed wearing correct personal protective clothing. Staff working in the kitchen have food handling certificates and chemical safety training. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | The reason for declining service entry to residents should this occur is communicated to the resident or family/ whanau and they are referred to the original referral agent for further information. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | PA Low | The initial support plan is developed with information from the initial assessment. Clinical risk assessments include continence, safe handling, falls risk, pressure area risk, nutritional assessment, cultural needs assessment, pain assessment, challenging behaviour and wound assessments are available for use applicable. Risk assessments were completed on admission. One resident with challenging behaviours had not had a behaviour assessment and another did not have the high falls risk identified prior to admission identified in their initial assessment. Risk assessment tools are used to identify the required needs and interventions required to meet resident goals. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Moderate | Resident centred care plans describe the individual support and interventions required to meet the resident goals in four of seven files reviewed. The care plans reflect the outcomes of risk assessment tools. Care plans demonstrate service integration and include input from allied health practitioners. Short term care plans were in use for changes in health status. There is documented evidence of resident/family/whanau involvement in the care planning process. Residents/relatives interviewed confirmed they participate in the care planning process. |
| 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 | A written record of each resident’s progress is documented. Changes are followed up by a registered nurse (evidenced in all residents' progress notes sighted). When a resident's condition alters, the registered nurse initiates a review and if required, a GP consultation or referral to the appropriate health professional is actioned. The clinical staff interviewed advised that they have all the equipment referred to in care plans necessary to provide care. Dressing supplies are available and a treatment rooms are well stocked for use. Wound documentation was reviewed and included wound assessment, treatment plans and evaluations and progress notes for all wounds. A wound care nurse specialist advice is readily available. Continence products are available and specialist continence advice is available as needed. Short term care plans with interventions and on-going evaluations by the RN were evidenced. A physiotherapist referral is initiated if required and assessment of any equipment needed |
| 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 Moderate | A diversional therapist commenced in September 2014 and a recreation assistant was employed in the last month. Activity assessments and plans are not always completed or within the required timeframes. Advised there is a plan in place to correct this with the additional support of the new recreation assistant. The programme covers a seven day week integrated rest home and hospital activity programme with care apartment rest home residents included. The programme is planned a month in advance and includes activities coordinated by the activity team, entertainers, themes and events. A two week plan is displayed in all resident rooms and on notice boards. The service has a wheelchair van utilised for outings each week. The DT has a current first aid certificate. Community links such as library, SPCA visits and gallery visits and walks within the village. Church services are held onsite twice a month. One on one contact is made with residents who are unable or choose not to participate in group activities, however not all residents have accessed group or one on one activities. Rest home and hospital advocate meetings provide an opportunity for residents to feedback on the programme. The activity assessment and individual plan is completed in consultation with the family on admission, however these are not undertaken within timeframes. Activity progress notes are maintained monthly. The activity team are involved in the MDT reviews. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | There is evidence of resident and family involvement in the review of resident centred care plans. Written evaluations were completed six monthly or earlier for resident health changes in files sampled. There is evidence of multidisciplinary (MDT) team involvement in the reviews. Short term care plans sighted have been evaluated by the RN. The GP completes three monthly reviews. Initial care plans were not always evaluated by the registered nurses within three weeks of admission (# link 1.3.3.3). |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | The service facilitates access to other services (medical and non-medical) and where access occurred, referral documentation is maintained. Residents' and or their family/whanau are involved as appropriate when referral to another service occurs. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Material Safety Data sheets are readily accessible for staff. Chemical bottles sighted have correct manufacturer labels. Chemicals are stored safely throughout the facility. The property manager is the approved handler for chemicals. Personal protective clothing is available for staff and seen to be worn by staff when carrying out their duties on the day of audit. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building has a current certificate of public use that expires on 1 June 2015. There is a full time property manager who is available on call for facility matters, he is supported by a fulltime property assistant/gardener. Planned and reactive maintenance systems are in place. All electrical equipment has been purchased new and is on a schedule for testing and tagging. Clinical equipment was purchased new for opening and is on a schedule for calibration and checking. Hot water temperatures have been tested and are on a monthly schedule with readings between 42-45 degrees Celsius. Preferred contractors are available 24/7.  Corridors are wide in all areas to allow residents to pass each other safely. There is safe access to all communal areas and outdoor areas. There is outdoor seating and shade. There is a designated smoking area for residents who smoke. The caregivers and registered nurses (interviewed) state they have all the equipment required to provide the care documented in the care plans. The following equipment is available: electric beds, ultra-low beds, sensor mats, standing and lifting hoists, mobility aids and wheel-on weigh scales. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | Visual inspection evidences toilet and shower facilities are of an appropriate design to meet the needs of the residents. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. All but six bedrooms have an ensuite. The six bedrooms without an ensuite share a spacious shower room and toilets. There are communal toilets located near the lounge/dining rooms. Communal toilet and shower facilities have a system that indicates if it is engaged or vacant. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | There is adequate room to safely manoeuvre mobility aids and transferring equipment such as hoists in the resident bedrooms. The doors are wide enough for ambulance trolley access. Residents and families are encouraged to personalize their rooms as viewed on the day of audit. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | Communal areas within the facility include open plan lounge and dining area for the rest home and hospital residents. There are smaller lounges, conservatories, seating alcoves and a family room within the care centre. The communal areas are easily accessible for residents. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. The laundry has a dirty to clean work flow. There are dedicated housekeeping staff and the laundry is undertaken by caregiving staff. All linen and personal clothing is laundered onsite. Cleaning trolleys are kept in designated locked cupboards. Residents and family interviewed report satisfaction with the cleaning and laundry service. Internal audits monitor the effectiveness of the cleaning and laundry processes. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | There are emergency and disaster manuals to guide staff in managing emergencies and disasters. Emergencies, first aid and CPR was included in the mandatory in-service programme. There is a first aid trained staff member on every shift. Summerset at Bishopscourt has an approved fire evacuation plan and fire dills occur six monthly. Smoke alarms, sprinkler system and exit signs in place. The service has alternative cooking facilities (gas cooktop and oven in the kitchen and two BBQs) available in the event of a power failure. Emergency lighting is in place for four hours. There are two civil defence kits in the facility and stored water. Call bells are evident in resident’s rooms, lounge areas, and toilets/bathrooms. The facility is secured at night with gates locked and controlled by staff to allow families and authorised personnel to gain entry. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | The service has an infection control (IC) programme. The infection control programme is appropriate for the size, complexity and degree of risk associated with the service and is linked into the quality reporting system (# link 3.5.7). A registered nurse is the designated infection control nurse with support from the nurse manager, and the infection control team since December 2014. The IC team meets to review infection control matters (# link 3.2.1). Minutes are available for staff. Regular audits have been conducted and education has been provided for staff. The IC programme is set out annually from head office and reviewed. The facility has developed links with the GP's, local Laboratory, the infection control and public health departments at the local DHB. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The infection control committee is made up of a cross section of staff from areas of the service including; (but not limited to) the nurse manager, the IC officer (RN) a caregiver and maintenance. The infection control officer was appointed to the designated role in December 2014. Prior to this the nurse manager reported IC matters at the quality meeting. The first IC formal minuted meeting was held in January 2015. The facility also has access to an infection control nurse specialist, public health, GP's and expertise within the organisation. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | There are comprehensive infection control policies that were current and reflected the Infection Control Standard SNZ HB 8134:2008, legislation and good practice. These are across the Summerset organisation and are regularly reviewed. The infection control policies link to other documentation and cross reference where appropriate. There are policies for IC management, b) implementing the IC programme, c) education, d) surveillance, and e) IC policies and procedures related to the prevention of transmission of infection. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The newly appointed infection control officer is responsible for coordinating/providing education and training to staff. The infection control officer (RN) has appropriate training for the role through the Summerset organisation. There is an annual organisation IC meeting and three monthly on line communication with the clinical and quality manager. The induction package includes specific training around hand washing and standard precautions and training is provided both at orientation and as part of the annual training schedule. Resident education is expected to occur as part of providing daily cares. Care plans include ways to assist staff in ensuring this occurs. |
| 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. | PA Low | Infection surveillance and monitoring is an integral part of the infection control programme and is described in infection monitoring policy. Monthly infection data is collected for all infections based on signs and symptoms of infection. Individual resident infection forms are completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. Surveillance of all infections was entered on to a monthly facility infection summary since November 2014, and staff were informed. The data has been monitored and evaluated monthly at facility and organisational level. The organisation also evaluated annually. The infection control data entered on line is reviewed by the Summerset clinical and quality manager monthly and any areas for improvement are to be highlighted and followed up with corrective actions by the nurse manager and infection control officer at the relevant facility. The facility is benchmarked against other Summerset facilities of similar size and benchmarking results are fed back to the infection control officer and used to identify areas for improvement. Staff receive infection control education during orientation and as per the education schedule. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There are policies around restraint, enablers and the management of challenging behaviours which meet requirements of HDSS 2008. Policy dictates that enablers should be voluntary and the least restrictive option possible. The service currently has three residents with restraint and one resident using an enabler. The resident has made a voluntary choice for enabler. The four resident files sampled reflect the use of restraint/enabler, have signed consents (# link 2.2.1.1) and risks identified with the use of the restraint/ enablers are identified in the care plan. The service applies the same policies/procedure for restraint and enablers. |
| Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | PA Moderate | Responsibilities and accountabilities for restraint are outlined in the restraint coordinators job description. The restraint coordinator was appointed to the position in December 2014. The restraint committee are scheduled to meet three monthly. There has been one formal documented restraint meeting (January 2015) for the approval and review of restraints and enablers. The nurse manager previously reported on restraint to the quality meeting. The resident (if appropriate) and relatives receive information on the use of restraints. Restraints are reviewed at a frequency as determined by organisational restraint minimisation policy and resident safety. There are three residents with restraint (bedrails/lap belts). Three files reviewed evidenced consent forms completed however these were signed after restraint was implemented.  Restraint education is included in care staff orientation. On-going education is provided and staff complete restraint competencies. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | PA Moderate | Summerset restraint minimisation policy outlines the organisation approach to managing restraint. This includes the use of a restraint assessment guide by the restraint coordinator and GP. The risk assessment includes a) to h) as listed in 2.2.2.1.  Four files reviewed documented an in-depth assessment including the consideration of alternatives however assessments were competed following application of restraint in three of four files reviewed. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | PA Moderate | Restraint policy states that the need for restraint use is monitored and reviewed as part of the six monthly review. Restraints have been evaluated monthly by the nurse manager and since December 2014 the nurse manager and the restraint officer. The service reviews all restraint use as part of the monthly quality meetings. Restraint monitoring and frequency is carried out as directed and includes documentation of the cares delivered to the resident during each episode of restraint. Restraint use is discussed at clinical meetings. Restraint is only used at the service as a last resort after all other alternative techniques to modify behaviour or manage resident safety has been exhausted. This is outlined as policy requirements in the restraint minimisation policy. There is a restraint/enabler register which is to be updated by the restraint coordinator as required. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | The use of restraining devices is evaluated by the restraint coordinator, nurse manager and registered nurses as part of the care planning review process in conjunction with the resident, their family/whanau and GP. Points a) to k) above are considered as part of this review. On review of four files (three restraints and one enabler) and with the delay in the restraint process there has been no formal evaluation required however the nurse manager has reviewed restraint monthly and has included the restraint coordinator in this process since December 2014. Restraint use is discussed at the monthly quality meetings. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | Summerset Bishopscourt reviews restraint use as part of its internal audit processes. The results of the restraint audit are discussed at the monthly quality meetings and any corrective actions identified are actioned through this forum. |

# Specific results for criterion where corrective actions are required

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

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

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | There is an annual audit schedule, surveys and quality data collected as per the organisation compliance calendar. Food surveys have been completed and analysed. | The results of the food survey (December 2014) reports some dissatisfaction with aspects of the food service. This has not been reported back to residents in the February newsletter or the February residents meeting. | Ensure that results of surveys are communicated to residents when appropriate.  90 days |
| Criterion 1.2.3.7  A process to measure achievement against the quality and risk management plan is implemented. | PA Low | The service holds a variety of meetings across the service including but not limited to; quality, health and safety, infecting control, restraint, clinical, care staff and domestic staff | Meeting minutes do not always document the person responsible for actions noted, the time frame to complete actions, any progress with the actions and sign off when the action has been completed. For example, a resident care plan audit in November 2014 documents in the RN meeting this needs completing/follow up by end of November 2014. In December 2014 the RN meeting minutes documents the nurse manager will follow up (no time frame, no progress notes). In the January 2015 RN meeting minutes there is no documentation of resident care plans (this has not been confirmed as completed). | Ensure that all meeting minutes include the person/persons responsible to address the actions, the time frame for completing, any progress notes and sign off when the action has been completed.  90 days |
| 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. | PA Low | The service is implementing an internal audit programme that includes aspects of clinical care and data collection. Issues arising from internal audits and data collection are developed into corrective action plans such as resident file reviews. | Issues arising from internal audits and surveys are not always developed into corrective action plans. There was a noted rise in resident falls from October 2014-December 2014 with no corrective action plan developed. There was no corrective action plan developed for dissatisfaction noted in the residents food survey December 2014 | Ensure that all quality data with identified areas for improvement have a corrective action plan developed so as to monitor and evaluate progress.  90 days |
| Criterion 1.3.12.5  The facilitation of safe self-administration of medicines by consumers where appropriate. | PA Moderate | Policy and procedures are in place for safe management of self-medication by residents. | One respite resident who was self-administering medication and had been in the facility for five days, did not have a medication chart, self-medication competency and no evidence of monitoring this administration. | Ensure all required documentation is completed for self-medicating residents.  30 days |
| Criterion 1.3.3.3  Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Low | One of five long term residents had the long term care plan developed within the expected time frame. | Four of five files did not have LTCP’s developed within the three week timeframe. | All long term residents to have long term care plans developed within the three week timeframe.  60 days |
| Criterion 1.3.4.2  The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning. | PA Low | Clinical risk assessment tools are available with supporting policies and procedures to guide staff. | (i) One respite resident had conflicting information on the initial assessment about independence.  ii) One resident with documented challenging behaviours had no behaviour assessment. | All assessments to be documented fully and accurately as per policy  60 days |
| Criterion 1.3.5.2  Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Moderate | Three of seven files evidenced resident centred care plans with interventions detailed to meet the resident needs. Shortfalls were identified in four care plans | i).The LTCP of a resident with challenging behaviours did not include behaviour management, triggers or de-escalation techniques. ii).A resident on warfarin did not have this or the risks identified in the LTCP. iii).A resident with a shoulder rotator cuff injury that required physiotherapy assessment and exercises did not have any documentation for this in a STCP or the LTCP; (iv) a resident with weight loss did not have interventions for this documented in a STCP or in the LTCP or the GP notified | Ensure all LTCPs include all identified needs/problems with interventions to manage and minimise all assessed risk and identified problems.  60 days |
| Criterion 1.3.6.1  The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Low | The clinical staff interviewed advised that they have all the equipment referred to in care plans necessary to provide care. Short term care plans with interventions and on-going evaluations by the RN were evidenced. | A resident requiring twice weekly weighs as requested by the GP had no evidence of this documented. | Ensure weights are monitored and documented as per instructions.  90 days |
| 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 Moderate | Timeframes are set and tools are available to assess and develop individual activities plans for all residents. | i).Activities assessments not undertaken within timeframes for seven of seven files reviewed (completed in one to six months).  ii).Respite resident had no activities assessment or knowledge of the activities programme.  iii).Three of five permanent residents had no activities plan.  iv).Two of two completed activities plans for resident files reviewed were not completed within timeframes (one no date, one six months)  v).Fourteen residents in the facility had no recorded participation in the activities programme in February 2015. | All residents to have activities assessments and individual activities plans completed within the set timeframes.  60 days |
| 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. | PA Low | Monthly infection data is collected for all infections based on signs and symptoms of infection. Individual resident infection forms are completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. Surveillance of all infections has been entered on to a monthly facility infection summary since November 2014. | The service identified through surveillance an increase in respiratory infections from November 2014-January 2015. There has been no evaluation or corrective outcomes initiated to address reduction and prevention and conclusions with recommendations. | Ensure all identified increase in infections are evaluated with corrective actions/recommendations implemented so as to reduce and prevent further possible infections  90 days |
| Criterion 2.2.1.1  The responsibility for restraint process and approval is clearly defined and there are clear lines of accountability for restraint use. | PA Moderate | Prior to the application of restraint/enabler residents/families are to be consulted so as to gain approval for restraint application. One resident using an enabler had a consent form signed appropriately. | Three residents currently with restraint have consents completed, however these were signed following application of restraint. One consent was signed six months after application of restraint, one consent was signed four months after restraint application and one restraint consent was signed one month after application of restraint. | Ensure that all residents requiring restraint/enabler have consents signed prior to application.  60 days |
| Criterion 2.2.2.1  In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to: (a) Any risks related to the use of restraint; (b) Any underlying causes for the relevant behaviour or condition if known; (c) Existing advance directives the consumer may have made; (d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes; (e) Any history of trauma or abuse, which may have involved the consumer being held against their will; (f) Maintaining culturally safe practice; (g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer); (h) Possible alternative intervention/strategies. | PA Moderate | Four residents with restraint/enabler have completed assessments. The resident using an enabler had the assessment completed appropriately. | All three restraint assessments have been completed after the application of restraint. One resident’s assessment was completed six months following application of restraint, one resident’s assessment was completed four months after application of restraint and one resident’s assessment was completed one month after application of restraint. | Ensure that all resident requiring restraint/enabler have assessments completed prior to application of restraint.  60 days |
| Criterion 2.2.3.4  Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to: (a) Details of the reasons for initiating the restraint, including the desired outcome; (b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint; (c) Details of any advocacy/support offered, provided or facilitated; (d) The outcome of the restraint; (e) Any injury to any person as a result of the use of restraint; (f) Observations and monitoring of the consumer during the restraint; (g) Comments resulting from the evaluation of the restraint. | PA Moderate | Residents with restraint and enablers are expected to be monitored two hourly when the restraint is applied. The resident using an enabler had documentation to support two hourly monitoring of bedrails. | Three residents with restraint do not have documentation to support two hourly monitoring over three consecutive days (2, 3 and 4 March 2015). | Ensure all residents with restraint or enablers have documented monitoring completed.  30 days |
| Criterion 2.2.3.5  A restraint register or equivalent process is established to record sufficient information to provide an auditable record of restraint use. | PA Low | The service completes a restraint/enabler register monthly. | The service does not have registers completed for the months of August, September, November and December 2014. | Ensure that the restraint/enabler register is completed every month.  90 days |

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

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

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

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

|  |
| --- |
| No data to display |

End of the report.