

# Summerset Care Limited - Summerset in the River City

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## 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](#).

The specifics of this audit included:

<b>Legal entity:</b>	Summerset Care Limited
<b>Premises audited:</b>	Summerset in the River City
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 12 March 2015 End date: 13 March 2015
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	42

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

Indicator	Description	Definition
	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 in the River City is part of the Summerset group. The facility is certified to provide hospital (geriatric and medical) and rest home level care for up to 37 residents in the care centre and 12 rest home residents in the serviced apartments. On the day of the audit there were 42 residents. The village manager and nurse manager are well qualified for their roles. There are developed systems and policies that are being implemented to guide care for residents. A quality programme is well implemented and embedded. An orientation programme and in-service training programme is in place that provides staff with appropriate knowledge and skills to deliver care. The service is to be commended for achieving continual improvements rating in good practice and implementation of quality improvement plans.

## 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.		All standards applicable to this service fully attained with some standards exceeded.
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Summerset in the River City 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.

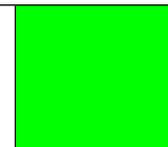
## Organisational management

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.		Standards applicable to this service fully attained.
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Summerset in the River City has a well embedded quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to a number of meetings including monthly quality meetings. Resident meetings are held monthly to provide an opportunity for feedback about the service. 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 well 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.

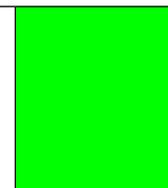


Standards applicable to this service fully attained.

Residents are assessed prior to entry to the service and a baseline assessment is completed upon admission. Registered nurses are responsible for care plan development with input from residents and family. Long term care plans reviewed were completed within policy timeframes. Residents and family interviewed confirmed that the care plans are consistent with meeting residents' needs. Planned activities are appropriate to the resident's assessed needs and abilities and residents advised satisfaction with the activities programme. Medications are managed and administered in line with legislation and current regulations. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

## 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.

Summerset in the River City has a current building warrant of fitness. Reactive and preventative maintenance is carried out. Chemicals are stored securely and staff are provided with personal protective equipment. Hot water temperatures are monitored and recorded. Medical equipment and electrical appliances have been calibrated by an authorised technician. Residents' rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. There are sufficient communal areas within the facility including lounge and dining areas, and small seating areas. There is a designated laundry and cleaner's room. The service has implemented policies and procedures for civil defence and other emergencies and six monthly fire

drills are conducted. External garden areas are available with suitable pathways, seating and shade provided. Smoking is only permitted in designated external areas.

## 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.		Standards applicable to this service fully attained.
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There are documented policies and procedures around restraint use and use of enablers. Currently there are four residents with restraint and one using 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. The service has safely reduced the number of residents using restraint and enablers.

## Infection prevention and control

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

<b>Attainment Rating</b>	<b>Continuous Improvement (CI)</b>	<b>Fully Attained (FA)</b>	<b>Partially Attained Negligible Risk (PA Negligible)</b>	<b>Partially Attained Low Risk (PA Low)</b>	<b>Partially Attained Moderate Risk (PA Moderate)</b>	<b>Partially Attained High Risk (PA High)</b>	<b>Partially Attained Critical Risk (PA Critical)</b>
<b>Standards</b>	1	49	0	0	0	0	0
<b>Criteria</b>	2	99	0	0	0	0	0

<b>Attainment Rating</b>	<b>Unattained Negligible Risk (UA Negligible)</b>	<b>Unattained Low Risk (UA Low)</b>	<b>Unattained Moderate Risk (UA Moderate)</b>	<b>Unattained High Risk (UA High)</b>	<b>Unattained Critical Risk (UA Critical)</b>
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Discussions with staff (five caregivers, three registered nurses, one property manager/maintenance, one chef and one diversional therapist) confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Seven residents (five rest home and two hospital) and 10 relatives (one rest home and nine hospital) were interviewed and confirmed the services being provided are in line with the Code.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need</p>	FA	<p>Informed consent and advanced directives were recorded as evidenced in the seven resident files reviewed (three rest home and four hospital). 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.</p>

to make informed choices and give informed consent.		
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	Residents are provided with a copy of the Code on entry to the service. Residents interviewed confirmed they are aware of their right to access independent advocacy services and advocacy pamphlets are available at reception. Discussions with relatives confirmed the service provided 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.
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. Activities programmes included opportunities to attend events outside of the facility including activities of daily living, for example, shopping and attending cafes and restaurants. Interview with staff, residents and relatives informed residents are supported and encouraged to remain involved in the community and external groups. Relative and friends are encouraged to be involved with the service and care.
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	The organisational complaints policy stated that the village manager has overall responsible for ensuring all complaints (verbal or written) are fully documented and investigated. There is a complaints register that included 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 11 complaints received in 2014 and four complaints in 2015. All complaints were fully documented with follow up letters and resolution. One complaint is still open and the district health board planning and funding manager is fully aware of the issue. The Health and Disability Commissioner has been involved and has signed off the complaint as being resolved. 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.

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>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 completed. Advocacy and code of rights information is included in the information pack and are available at reception.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>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 weekly and resident files include cultural and spiritual values. Contact details of spiritual/religious advisors are available to staff. 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.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>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.</p>	<p>FA</p>	<p>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 was one resident that identified as Maori.</p>
<p>Standard 1.1.6: Recognition And</p>	<p>FA</p>	<p>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</p>

<p>Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>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.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>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 and have attended training.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>CI</p>	<p>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.</p> <p>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 ongoing 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 &amp; 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. RNs have access to external training.</p> <p>The service is commended for achieving a continued improvement rating around providing an environment that encourages good practice.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>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 are held 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 produces a newsletter 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 residents were English speaking on the day of the audit.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The service provides care for up to 49 residents at hospital (geriatric and medical) and rest home level care. On the day of the audit, there were 42 residents in total, 19 residents at rest home level (six are in the service apartments and includes two residents on integrated care) and 23 residents at hospital level including two residents on integrated 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 in the River City 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 in the River City 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 four 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 18 months and has a considerable background in nursing and has worked in aged care for the last six years. 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.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and</p>	<p>FA</p>	<p>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.</p>

<p>effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>		
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>Summerset in the River City 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.</p> <p>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 ongoing monitoring programme.</p> <p>There is a meeting schedule including monthly quality meetings that includes discussion about clinical indicators (e.g. incident trends, infection rates) registered nurse meetings, health and safety, infection control meetings and restraint meeting three monthly. There are other meetings being held such as care staff, kitchen and activities.</p> <p>Resident/family meetings are held monthly with an advocate from Age Concern attending every three months. An annual residents/relatives survey completed (October 2014) reports overall 94% feedback of experience being good or very good. Feed back to residents was given and documented in the resident meeting January 2015.</p> <p>The service is implementing an internal audit programme that includes aspects of clinical care. Issues arising from internal audits are developed into corrective action plans. Monthly and annual analysis of results is completed and provided across the organisation. The service has been awarded a continuous improvement in respect of the work completed against two 2014 objectives. There are monthly accident/incident benchmarking reports completed by the nurse manager that break down the data collected across the rest home and hospital and staff incidents/accidents. Infection control is also included as part of benchmarking across the organisation. Health and safety 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- The Summerset Way". 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. One of the registered nurses 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. Reduction of falls has been one of the objectives of the service in 2014.</p>

<p>Standard 1.2.4: Adverse Event Reporting</p> <p>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.</p>	<p>FA</p>	<p>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 is linked to the organisation's benchmarking programme and used for comparative purposes.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>There are human resources policies to support recruitment practices. A list of practising certificates is maintained. Six staff files were reviewed and all had relevant documentation relating to employment. Performance appraisals are completed annually. 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 staff). 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. Somerset organisation employs a clinical education manager who is a registered nurse with a current practising certificate. The nurse manager facilitates the orientation programme for new staff and support the on-going education programme. Caregivers complete an aged care programme. There are 20 permanent caregivers employed currently, 16 have completed an aged care programme and four are enrolled in the training programme. In 2015 two registered nurses are undertaking post graduate studies with supporting scholarships through the district health board. Two registered nurses have completed the training to be aged care training programme assessors. Four of six registered nurses have completed the professional development recognition programme, one other is enrolled in the programme and one is newly employed. All staff receive a certificate each year for education completed.</p>

<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>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.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident files were appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry 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 are protected from unauthorised access by being held in a locked cupboard. 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 is 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.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>The service had comprehensive admission policies and processes in place. Residents receive an information booklet around admission processes and entry to the service. The nurse manager screens all potential residents prior to entry to services to confirm they meet the level of care provided at the facility. Residents and relatives interviewed confirmed they received information prior to admission and discussed the admission process and admission agreement with the village manager/nurse manager.</p>

<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>The transfer /discharge/exit procedures include a transfer/discharge form and the completed form is placed on file. The service stated that a staff member escorts the resident if no family are available to assist with transfer, and copies of documentation are forwarded with the resident.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The service uses individualised robotic medication blisters which are checked in on delivery. Two registered nurses were observed administering medications correctly. Medications and associated documentation were stored safely and securely and all medication checks were completed and met requirements. Resident photos and documented allergies or nil known were on all 14 medication charts reviewed. An annual medication administration competency is completed for all staff administering medications and medication training has been conducted.</p> <p>There is a self-medicating resident's policy and procedures in place. There were currently no residents who self-administered medications. Individually prescribed resident medication charts are in use and this provides a record of medication administration information. All 14 medication charts reviewed recorded indication for use of as required medication by the GP. As required medication is reviewed by a registered nurse each time prior to administration, pain assessments were undertaken before administering as required analgesia. Medication charts reviewed identified that the GP had reviewed the resident three monthly and the medication chart was signed.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>An external company is contracted for the provision of meals on-site. There is an eight week rotating menu approved and last reviewed by the dietitian on 20 February 2015. 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. Supplements are provided to residents with identified weight loss issues. Weights are monitored monthly or more frequently if required and as directed by a dietitian. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed indicated satisfaction with the food service.</p> <p>The kitchen is well equipped. 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</p>

		in the kitchen have food handling certificates and chemical safety training.
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>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.</p>	FA	The service records the reasons for declining service entry to residents should this occur and communicates this to residents/family/whānau. Anyone declined entry is referred back to the needs assessors or referring agency for appropriate placement and advice.
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>All appropriate personal needs information is gathered during admission.</p> <p>Risk assessment tools were sighted as completed and reviewed at least six monthly or when there was a change to a resident's health condition. Care plans reflected the outcome of the risk assessments for the seven resident files sampled.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	The long term care plan includes nursing diagnosis, actual or potential/deficits, outlined objectives of nursing care, setting goals, and details of implementation. Resident/family/whānau involvement in the care planning process was evidenced by signatures on the written acknowledgment of care plan form in the resident files sampled. Residents and relatives interviewed and resident files sampled confirmed that resident/family were involved in the development/evaluation of care plans. Short term care plans were in use for changes in health status.

<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>A written record of each resident's progress is documented. Changes are followed up 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 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, 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.</p> <p>Monthly care plan audits ensure that care plans are assessed by the nurse manager and meet resident need.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>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.</p>	<p>FA</p>	<p>The activities staff provide an activities programme over seven days each week, diversional therapist Tuesday to Saturday and a caregiver (commencing DT training) working Sunday and Monday. The programme is planned monthly and residents receive a personal copy of planned monthly activities. Activities plan for the month are displayed in large style colour format on notice boards around the facility. A diversional therapy plan is developed for each individual resident based on assessed needs. Residents are encouraged to join in activities that are appropriate and meaningful and are encouraged to participate in community activities. The service has a van that is used for resident outings and a car that is used for resident transport. Residents were observed participating in activities on the days of audit. Resident meetings (monthly) provide a forum for feedback relating to activities and are chaired by an advocate (three monthly). Residents who are unable to or choose not to participate are visited for one on one discussion and activities at least weekly. Residents and family members interviewed discussed enjoyment in the programme and the diversity offered to all residents.</p> <p>The diversional therapist has been instrumental in organising the walking programme towards the service reducing the number of resident falls (# link 1.2.3.7).</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Care plans reviewed were updated as changes were noted in care requirements. Care plan evaluations are comprehensive, related to each aspect of the care plan and recorded the degree of achievement of goals and interventions. Short term care plans are utilised for residents and any changes to the long term care plan were dated and signed. Short term care plans were in use. Care plans are evaluated within the required time frames.</p>

<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>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.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>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 were 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.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an</p>	<p>FA</p>	<p>The building has a current warrant of fitness that expires on 2 February 2016. There is a full time property manager who is available on call for facility matters. Planned and reactive maintenance systems are in place. All electrical equipment is on a schedule for testing and tagging and was last completed in July 2014. Clinical equipment is on a schedule for calibration and checking, next scheduled for April 2015. Hot water temperatures have been tested and</p>

<p>appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>are on a monthly schedule with readings between 42-45 degrees Celsius. Preferred contractors are available 24/7.</p> <p>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.</p> <p>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.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>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.</p>	<p>FA</p>	<p>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. Six bedrooms have an ensuite with two other rooms sharing an ensuite. The remainder of resident rooms share bathroom and toilet facilities. 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.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>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 personalise their rooms as viewed on the day of audit.</p>

<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>There is a large lounge and dining room, and two conservatories within the care part of the facility. The dining room is spacious, and located directly off the kitchen/servery area. All areas are easily accessible for the residents. The furnishings and seating are appropriate for the consumer group. Residents interviewed report they were able to move around the facility and staff assisted them when required. Activities take place in the lounge.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>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 is dedicated housekeeping staff and the laundry is undertaken by caregiving staff. All linen and personal clothing was 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.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>There are emergency and disaster manuals to guide staff in managing emergencies and disasters. Emergencies, first aid and CPR are included in the mandatory in-service programme. There is a first aid trained staff member on every shift. Summerset in the River City has an approved fire evacuation plan and fire drills occur six monthly. Smoke alarms, sprinkler system and exit signs in place. The service has alternative cooking facilities (two gas 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.</p>

<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>Visual inspection evidences that the residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>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.</p>	FA	<p>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. A registered nurse is the designated infection control nurse with support from the nurse manager, and the infection control team. The IC team meets to review infection control matters. 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.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the</p>	FA	<p>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 role over four years ago. The IC committee meets three monthly. The facility also has access to an infection control nurse specialist, public health, GP's and expertise within the organisation.</p>

infection control programme and meet the needs of the organisation.		
<p>Standard 3.3: Policies and procedures</p> <p>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.</p>	FA	<p>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.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control officer is responsible for coordinating/providing education and training to staff. The infection control coordinator (RN) has appropriate training for the role through the Summerset organisation and has attended DHB ICP updates. 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.</p>

<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>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. The service has recently introduced a new “pink form” for each individual infection recording. Surveillance of all infections is entered on to a monthly facility infection summary and staff are 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 Somerset 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 Somerset 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. The service effectively managed a gastroenteritis outbreak in December 2014 which was not confirmed as norovirus. The DHB and public health were appropriately informed.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>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 four residents with restraint and one resident using an enabler. The resident has made a voluntary choice for enabler. The three resident files (two restraint and one enabler) sampled reflect the use of restraint/enabler, have signed consents 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. One of the goals of the service from 2014 was to reduce the use of restraint. The service has been proactive in reducing restraint and enabler use and implemented a quality goal/improvement plan (# link 1.2.3.7). Restraint and enabler use has safely reduced.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and</p>	<p>FA</p>	<p>Responsibilities and accountabilities for restraint are outlined in the restraint coordinators job description. The restraint coordinator is the nurse manager and has been in the position for 18 months. The restraint committee meet three monthly and discuss all residents using restraints or enablers. 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 four residents with restraint (one bedrails and three lap belts). Two files reviewed evidenced consent forms completed.</p> <p>Restraint education is included in care staff orientation. Ongoing education is provided and staff complete restraint competencies.</p>

procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.		
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	<p>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.</p> <p>Three files reviewed documented an in-depth assessment including the consideration of alternatives prior to application of restraint/enabler.</p>
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	<p>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 (restraint coordinator). 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 and at least monthly.</p>
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	<p>The service has documented evaluation of restraint every three months. In the files reviewed, evaluations had been completed with the resident, family/whanau, restraint co-ordinator and medical practitioner. Restraint practices are reviewed on a formal basis every month by the facility restraint co-ordinator at quality and staff meetings meeting. Evaluation timeframes are determined by risk levels. The evaluations have been completed with the resident, family/whanau, restraint co-ordinator and medical practitioner.</p>
Standard 2.2.5: Restraint Monitoring	FA	<p>The service 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.</p>

and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.		
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## Specific results for criterion where corrective actions are required

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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.

No data to display
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>The service has a robust quality and risk programme that is managed by the village and nurse manager and supported by the national clinical and quality coordinator. Policies and procedures are reviewed regularly to support current accepted best and/or evidenced based practice. The facility has a master copy of all policies and procedures and a master copy of clinical forms. The content of policy and procedures are detailed to allow effective implementation by staff.</p> <p>There is a structured two year education programme for all staff and professional staff are encouraged to continue formal education. Core competency assessments and orientation programmes have been implemented at the service.</p>	<p>The quality system is supported by a published clinical and training calendar which provides an annual month by month plan of all audit compliance and training tasks. Each month head office sends a “best practice” sheet (BPS), based on the clinical audit and training calendar and other quality initiatives to all care centres and the village manager/nurse manager must confirm they have undertaken all tasks. This was fully implemented at the service. The BPS serves as a reminder to care centre management and also provides guidance on quality initiatives such as falls prevention and action plans for organisation wide initiatives.</p> <p>The service has implemented the Summerset meeting structure which supports the quality system. There are a number of meetings held on a regular basis including but not limited to; monthly quality meetings, weekly management meetings and staff meetings, health and safety, quality infection control and restraint meetings three monthly, monthly registered nurses meetings and other meeting such</p>

		<p>There are implemented competencies for caregivers, enrolled nurses and registered nurses. There are clear ethical and professional standards and boundaries within job descriptions. Competencies are completed for key nursing skills at the service. All qualified staff at the service have current first aid certificates. The service has reduced the use of restraint and enablers and number of resident falls through staff education and a robust falls prevention programme which focuses on the individual resident for the best possible outcome. Discussions with two hospital residents and five rest home, nine hospital and one rest home relatives were positive about the care they receive.</p>	<p>as kitchen and diversional therapy/activity meetings.</p> <p>Standardised policy and procedures annual education programme, core competency assessments and orientation programmes is well implemented at the service.</p> <p>At the time of audit 16 of 20 permanent caregivers have completed an aged care programme and four are enrolled in the training programme. The service encourages scholarship application for registered nurses wishing to pursue their nursing knowledge. In 2015 two registered nurses are undertaking post graduate studies with supporting scholarships through the district health board. Two registered nurses have completed the training to be aged care training programme assessors. Four of six registered nurses have completed the professional development recognition programme, one other is enrolled in the programme and one is newly employed. All staff receive a certificate each year for education completed.</p> <p>At an organisational level there is a policy and procedure review committee to maintain “best practice” guidelines/procedure. This group meets every month and involves members of the executive team including the chief executive office, general manager operations, operations manager, clinical education manager and clinical quality manager. The organisation has a number of quality projects running including reducing falls.</p> <p>The service is proactive by following through and identifying quality improvements from internal audits, incidents/accidents, complaints as well as skin tears, falls, urinary tract infections and pressure area strategies. Quality improvement corrective action plans are established when above the benchmark. Benchmarking includes but not limited to: medication error, pressure areas, falls, skin ears infections polypharmacy and weight loss. Each action plan includes action, progress, evaluation and further recommendations as required.</p>
Criterion 1.2.3.7	CI	Summerset has an organisational total quality management plan and a policy outlining the purpose, values and goals. Quality objectives and	Summerset in the River City had identified two quality improvement objectives for the 2014 year. Each had been developed in response to quality data analysis and included an aim and proposed method of

<p>A process to measure achievement against the quality and risk management plan is implemented.</p>		<p>quality initiatives from an organisational perspective are set annually and each facility then develops their own specific objectives. Service specific objectives are reviewed as prescribed in the quality meetings.</p> <p>The service had two main objectives for 2014; Falls reduction plan, to reduce falls by 20% and to decrease the number of restraints and enablers used by 20%. The quality improvement plan process had been used to plan and evaluate progress towards each objective. Progress towards objectives was seen to have been discussed at the various staff meetings. Both objectives have positive results when evaluated in January 2015 and will remain ongoing objectives for 2015.</p> <p>The service has confirmed other new objectives for 2015 including elimination of facility acquired pressure sores.</p>	<p>achievement. This continuous improvement has been awarded based on the results achieved against the two objectives. A brief summary follows:</p> <p>a) Reduction of resident falls by 20%. The objective was established in respect of quality data analysis. The intent of the objective was to reduce the number of resident falls. Implementation included a falls programme to ensure that all residents were walked on a regular basis. Caregivers and the diversional therapist were allocated residents to be responsible for regular walking of residents. This included completing a walking diary with comments about each resident and evaluation of the comments were completed each week with progress documented by the registered nurses. Walking champions were established. Seats were placed in strategic places around the facility to allow residents to rest. The resident care plans included details of toileting and transfer details to allow the walking programmes to be implemented. Action plans were in place for those residents with a history of frequent falls and included more frequent checks of the resident. Evaluation of the collated data showed a decrease in fall rate from July 2014 when all falls reported was a total of 16 to February 2015 when the total of all falls was reported as five. This is a positive result and will continue as a remaining goal for 2015.</p> <p>b) Decrease in the number of restraint and enablers used by 20%. This objective was developed to reduce the number of restraints and enablers being used. In order to achieve this goal education was completed for caregivers and registered nurses by the restraint coordinator. One on one education sessions were completed for families on the disadvantage of restraint. All residents currently with restraint were reassessed and trailing off restraint was established. Short- term care plans were implemented for trailing off restraint and for monitoring purposes. Additional equipment was purchased including anti-roll mattresses and more sensor mats. Evaluation of the data collated in January 2015 reports a 16 % reduction in the use of restraint and enabler use. In May 2014 there were 16 residents with restraint and six residents using enablers. In January 2015 there were four residents with restraint and two residents with enablers. On the day of the audit there were four residents with restraint and one resident using an enabler. The goal will remain ongoing through</p>
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End of the report.