

# Summerset Care Limited - Summerset Down The Lane

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## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

<b>Legal entity:</b>	Summerset Care Limited
<b>Premises audited:</b>	Summerset Down the Lane
<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: 8 January 2016 End date: 8 January 2016
<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>	54

# 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
Yellow	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
Red	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

## General overview of the audit

Summerset Down the Lane provides rest home and hospital level care for up to 69 residents and on the day of the audit there were 54 residents. The service is managed by a village manager and a nurse manager. The residents and relatives interviewed spoke positively about the care and support provided.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the District Health Board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management and staff.

The service has addressed one of the six previous findings from the previous certification audit around the activities programme. Improvements continue to be required in relation to communicating quality and risk data results to staff; corrective action plans; incidents and accidents; interventions; and medication management.

The service has addressed two of the two previous findings from the partial provisional certification audit around the installing all furnishings and the call bell system.

This surveillance audit identified four high risk findings in service delivery. Improvements are also required in relation to open disclosure, complaints management, meeting timeframes for care planning, progress note documentation, residents' assessments, and care plans.

## Consumer rights

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Residents and families interviewed report that they are kept informed. Residents and their family/whanau are provided with information on the complaints process on admission. Staff are aware of the complaints process and to whom they should direct complaints.

## Organisational management

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Services are planned and are appropriate to the needs of the residents. A village manager and nurse manager/registered nurse are responsible for the day-to-day operations of the facility. They were both recently employed. Quality and risk management

processes have been established. The risk management programme includes a risk management plan, incident and accident reporting, and health and safety processes.

Residents receive services from qualified staff. Human resources are managed in accordance with good employment practice, meeting legislative requirements. An orientation programme is in place for new staff. On-going education and training for staff is in place.

Registered nursing cover is provided 24 hours a day, seven days a week. There are adequate numbers of staff on duty to ensure residents are safe.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family/whanau input. Care plans viewed in residents' records demonstrated service integration. Residents' files included medical notes by the contracted GP and visiting allied health professionals. A number of shortfalls have been identified around service delivery management.

The diversional therapist and activities team provide an activities programme for the residents that is varied, interesting and involves the families/whanau and community.

Medication policies comply with legislative requirements and guidelines. Registered nurses responsible for administration of medicines complete education and medication competencies.

All meals are prepared on site by an external contractor. Food, fridge and freezer temperatures are recorded. Individual and special dietary needs are catered for. Residents and family/whanau interviewed responded favourably to the food that was 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.
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A current building warrant of fitness is posted in a visible location.

## 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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Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraints and enablers. The service had two residents who voluntarily required enablers and one resident assessed as requiring the use of restraint.

## Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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The infection control surveillance programme is appropriate to the size and complexity of the service. Results of surveillance are acted upon, evaluated and reported to relevant personnel.

## 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	10	0	1	4	4	0
Criteria	0	29	0	2	8	4	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](#).

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 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>PA Moderate</p>	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission. Interviews with six residents (three rest home level and three hospital level) and one family member confirmed their understanding of the complaints process. Care staff interviewed (three caregivers, six registered nurses (RNs), one diversional therapist, one activities coordinator) were able to describe the process around reporting complaints.</p> <p>There is an electronic complaints register that includes verbal and written complaints. The complaints register was not up-to-date. Also missing was consistent evidence of complaints being managed in a timely manner including acknowledgement, investigation, time lines, and corrective actions when required and resolutions (link 1.2.3.8).</p> <p>Complainants are provided with information on how to access advocacy services through the Health and Disability Commissioner if resolution is not to their satisfaction.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively</p>	<p>PA Low</p>	<p>An open disclosure policy describes ways that information is provided to residents and families. The admission pack includes a comprehensive range of information regarding the scope of service provided to the resident and their family on entry to the service and any items they have to pay that is not covered by the agreement. Regular contact is maintained with family including if an incident or care/ health issues arises. One family</p>

<p>with consumers and provide an environment conducive to effective communication.</p>		<p>member interviewed (hospital level, tracer resident) stated they were kept informed although this was unable to be evidenced in six of 15 accident/incident reports (also link 1.2.4.3).</p> <p>The service has policies and procedures available for access to DHB interpreter services and residents. The information pack is available in large print and can be read to residents. Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so.</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>Summerset Down the Lane provides rest home and hospital level care for up to 49 residents in the care centre with an additional 20 serviced apartments suitable for rest home level of care. On the day of the audit there were 54 residents with 26 at rest home level and 22 at hospital level of care in the care facility and six at rest home level of care in the serviced apartments. All residents' rooms in the care facility are dual purpose and all 54 residents living at the facility during this surveillance audit were on the aged-related care contract (ARCC).</p> <p>The site includes a retirement village with overall management of the site provided by a village manager. The village manager was employed by Summerset on 14 December 2015. Prior to this she was employed in Melbourne managing a backpacker hostel. She holds Masters in Business Administration (2011). The nurse manager is a registered nurse employed to oversee the running of the care facility and serviced apartments. She was also employed on 14 December 2015. She has held numerous roles as a registered nurse (1982), holds a postgraduate certificate in the Older Person in Rehabilitation Services (2012) and has worked in four district health boards (DHBs). This is her first role in an aged care facility.</p> <p>A 2015 strategic plan is in place for the organisation that includes annual goals and objectives.</p> <p>The village manager and nurse manager hold minimum of eight hours of professional development activities related to managing an aged care facility based on the number of hours that have been devoted to their induction to the Summerset organisation and this facility. Their induction programmes are still in process.</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</p>	<p>PA Moderate</p>	<p>A quality and risk management plan is in place. Quality is overseen by the organisation's clinical quality manager. Policies and procedures reflect evidence of regular reviews as per the document control schedule. New and/or revised policies are made available for staff to read and sign that they have read and understand the changes. Village managers and nurse managers are held accountable for their implementation.</p> <p>The monthly collating of quality and risk data includes (but is not limited to) residents' falls, infection rates, skin tears and pressure areas. Data is collated and benchmarked against other Summerset facilities to identify trends. A resident satisfaction survey is conducted each year. Results for 2015 reflect analyses of the data with an action plan documented. An annual internal audit schedule was sighted with audits completed as per the schedule.</p>

improvement principles.		<p>Corrective actions are not routinely developed where indicated (link 1.1.13.3). Also missing was evidence of the implementation and evaluation of corrective action plans that were developed. Staff are not routinely kept informed regarding quality and risk findings, and corrective actions. These previous areas identified for improvements remain.</p> <p>A falls reduction plan was sighted for the service. Falls prevention strategies are in place that include the identification of interventions on a case-by-case basis to minimise future falls. Sensor mats and physiotherapy services are utilised.</p> <p>The health and safety programme is overseen by a health and safety team. Hazard identification forms and a hazard register are in place.</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>PA Moderate</p>	<p>The service collects a comprehensive set of data relating to adverse, unplanned and untoward events, which is linked to the quality and risk management system (link 1.2.3.6 and 1.2.3.8). This includes, but is not limited to, the collection of incident and accident information. Data is uploaded electronically by the village manager that inappropriately implies that she, as a non-clinician, has investigated each adverse event. Staff designations are not being documented on accident/incident forms.</p> <p>Once incidents and accidents are reported the immediate actions taken are documented on incident forms. The incidents forms are then reviewed and investigated. If risks are identified these are processed as hazards.</p> <p>Two significant incidents that were subsequently lodged as complaints by family members did not have accident/incident forms completed (link 1.1.13.3). This previous area identified for improvement remains.</p> <p>Discussions with the village manager and nurse manager have confirmed their awareness of statutory requirements in relation to essential notification. This information is also provided by the Summerset organisation in hard copy as reference material.</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 job descriptions available for all relevant positions that describe staff roles, responsibilities and accountabilities. The practising certificates of nurses are current. The service also maintains copies of other visiting practitioners practising certificates including GP, pharmacist and physiotherapist. Five staff files were reviewed (three caregivers and two registered nurses). Evidence of signed employment contracts, job descriptions, orientation, and staff training were available for sighting. Annual performance appraisals for staff are regularly conducted. Newly appointed staff complete an orientation that is specific to their job duties. Interviews with three caregivers described the orientation programme that includes a period of supervision.</p> <p>The service has a training policy and schedule for in-service education. The in service schedule is implemented and attendance is recorded. For those staff members who are unable to attend education, a competency is</p>

		<p>completed.</p> <p>There are implemented competencies for registered nurses including (but not limited to); medication, restraint, syringe driver and insulin administration (also link 1.3.3.1).</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 service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. An RN is scheduled 24 hours a day, seven days a week. In addition to the RN, there are a minimum of two caregivers rostered. Staff reported that staffing levels and the skill mix was appropriate and safe. One family and six residents interviewed advised that they felt there was sufficient staffing. The roster is able to be changed in response to resident acuity.</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>	PA High	<p>Ten medication charts were reviewed (six rest home- including two rest home level of care in the serviced apartments and four hospital) There are policies and procedures in place for safe medicine management that meet legislative requirements. All clinical staff who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Staff were observed to be safely administering medications. Registered nurses interviewed were able to describe their role in regard to medicine administration. Standing orders are not used. There were no residents self-medicating on the day of audit.</p> <p>The medication fridge temperatures are recorded regularly and these are within acceptable ranges. The previous audit findings relating to medication fridge temperatures and GP signatures for discontinued medications have been met.</p> <p>Not all PRN medication had indications for use charted. It was unclear if all prescribed medication had been administered. There was a lack of evidence of open disclosure for two medication errors (link 1.1.9.1).</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</p>	FA	<p>All meals at Summerset Down the Lane are prepared and cooked on site by an external contactor. There is an eight weekly seasonal menu which had been reviewed by a dietitian. Meals are delivered to the dining area. Dietary needs are known with individual likes and dislikes accommodated. Pureed, gluten free, diabetic desserts are provided. Cultural and religious food preferences are met.</p> <p>Staff were observed assisting residents with their meals and drinks. Supplements are provided to residents with identified weight loss issues. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed were satisfied with the food</p>

<p>service delivery.</p>		<p>and confirmed alternative food choices were offered for dislikes.</p> <p>Fridge, freezer and chiller temperatures are taken and recorded daily. End cooked food temperatures are recorded daily.</p> <p>All food services staff have completed training in food safety and hygiene and chemical safety.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>PA High</p>	<p>The facility has embedded the InterRAI assessment protocols within its current documentation. One RN (Clinical Leader) is currently trained in the use of InterRAI. InterRAI initial assessments and assessment summaries were not evident in printed format in the files reviewed. The InterRAI assessment information reviewed did not always reflect accurately the resident's current status.</p> <p>Additional assessments tools for management of behaviour, and wound care were available for use. Not all residents' experiencing pain had pain assessments completed. Initial wound assessments were completed and documented by the RN, however not all initial assessment information was documented for all wounds and pressure injuries. (link 1.3.6.1)</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA High</p>	<p>The RN's are responsible for all aspects of care planning. The care plans reviewed did not all demonstrate service integration and input from allied health. Not all care plans included specific interventions for all identified care needs. Care plans were not always documented to reflect acute changes in health status. Family/whānau members interviewed confirmed the care delivery and support by staff is consistent with their expectations.</p>
<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>PA High</p>	<p>When a resident's condition alters, the registered nurse initiates a review and if required, GP or nurse specialist consultation. The family member confirmed on interview they are notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications (link 1.1.9.1).</p> <p>In the residents' files reviewed short term care plans were commenced with a change in health condition (link 1.3.5.2). Interventions documented in the care plans were not always implemented. Long term care plans were not all reviewed six monthly (link 1.3.8.2)</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. Registered nurses were able to describe access for wound and continence specialist input as required.</p>

		Dressing supplies were sighted in treatment rooms; however the dressing supplies required for dressings were not always available. Wound care plans were not always updated with a change in the wound. (link 1.3.4.2).
<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>	FA	<p>The recreational programme provides individual and group activities that are meaningful and reflect ordinary patterns of life. The monthly programme includes walking groups, community outings, visiting preschool groups, craft and fitness programmes. On the day of audit residents were observed participating in a variety of activities. One on one activities are provided for residents who are unable or choose not to be involved in group activities.</p> <p>The diversional therapist is responsible for the resident's individual recreational and lifestyle plans which are developed within the first three weeks of admission. The resident/family/whanau, as appropriate, are involved in the development of the activity plan. Resident files reviewed identified that the individual activity plan is reviewed as part of the care plan review.</p> <p>Activities are planned that are appropriate to the functional capabilities of residents. Residents are able to provide feedback and suggestions for activities at the quarterly resident meetings and annual resident satisfaction survey.</p> <p>Residents and families interviewed report satisfaction with the activities programme.</p> <p>The recreational programme is staffed seven days per week and is delivered by a diversional therapist and a recreational therapist (commenced at Summerset one month ago.) The previous audit finding related to the implementation of the planned activity programme has been addressed.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>In the residents' files reviewed not all initial assessments and care plans documented by RN had been evaluated and transferred to the long term care plan (Link 1.3.3.3). Short term care plans documented for acute changes in health condition had not all been evaluated and linked to the long term care plan. (Link 1.3.5.2). The GP reviews the residents at least three monthly or earlier if required. Evidence of three monthly GP reviews was not seen in all residents' files sampled (link 1.3.3.3). The registered nurses advised that on-going nursing evaluations occur daily, however this was not always evidenced in the progress notes or care plans. (Link 1.3.3.3). Six monthly written care plan evaluations occur.</p> <p>The activity care plan is reviewed at the same time as the long term care plan.</p>
<p>Standard 1.4.2: Facility Specifications</p>	FA	<p>There is a preventative and reactive maintenance programme in place. There is a calibration programme for medical equipment and electrical safety checks. The recently built bedrooms and serviced apartments include</p>

<p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>appropriate fixtures, fittings and furnishings. This is an improvement from the partial provisional audit that took place in February 2015.</p> <p>A current building warrant of fitness is displayed and expires on 4 December 2016.</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>An electronic call bell system is in place. All residents were observed to have access to call bells in their rooms. This is an improvement from the previous partial provisional audit</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>Policies and procedures document infection prevention and control surveillance methods. The surveillance data is collected and analysed monthly to identify areas for improvement or corrective action requirements. Infection control internal audits have been completed. Infection rates have been low. Trends are identified and quality initiatives are discussed at staff meetings. There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place appropriate to the complexity of service provided.</p> <p>There have been no outbreaks since the previous audit. Systems are in place are appropriate to the size and complexity of the facility.</p> <p>Infection monitoring is the responsibility of the infection control coordinator (enrolled nurse). The infection control policy describes routine monthly infection surveillance and reporting. Monthly surveillance activities are appropriate to the acuity, risk and needs of the residents. There have been no outbreaks. Infection types and numbers are entered into the 'sway' database, which generates a monthly analysis of the data. The analysis is reported to the monthly combined infection control and health and safety meetings. Infection control is discussed at clinical meetings and staff handovers. An infection control board has been set up for the display of topical infection control information and monthly graphs. An infection control audit in January 2015 had 100% compliance. Organisational benchmarking occurs against facilities of similar size. The previous CI remains.</p>
<p>Standard 2.1.1: Restraint</p>	<p>FA</p>	<p>There are policies around restraints and enablers. The service currently has one hospital level resident</p>

<p>minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>		<p>assessed as requiring the use of restraint and two residents voluntarily requesting bedrails as enablers.</p> <p>Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers.</p>
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## 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)
<p>Criterion 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p>	<p>PA</p> <p>Moderate</p>	<p>Policies and procedures for the organisation detail the complaints process, which meets requirements set forth by the Health and Disability Commissioner.</p> <p>The management staff are instructed to load all complaints received into an electronic complaints register database. This electronic register was not up-to-date for 2015. Missing was evidence of all complaints received being logged into the register and evidence of the complaints process being followed consistently for each complaint received.</p>	<p>i) The 2015 complaints register was not up to date with evidence of three complaints discussed in management meetings that were not logged in the complaints register. Furthermore, detail relating to each complaint is not being consistently uploaded electronically into the electronic complaints register.</p> <p>ii) Ten of twenty-eight complaints received in 2015 were not acknowledged.</p> <p>iii) The complaints register failed to verify that two potentially high risk complaints received in 2015 were addressed. One complaint (from a family member) related to a resident who missed their medication for two</p>	<p>Ensure that all complaints are managed as per the Health and Disability Commissioner's requirements. Ensure all details relating to each complaint received are held in the complaints register to verify that complaints are being addressed.</p> <p>60 days</p>

			<p>days and a second complaint (from a family member) related to a resident who fell and passed away two days later.</p> <p>It was noted that, complaints management is a historic problem and recent new complaints have been followed up in a timely manner and therefore the risk has been identified as low.</p>	
<p>Criterion 1.1.9.1</p> <p>Consumers have a right to full and frank information and open disclosure from service providers.</p>	PA Low	<p>Staff are instructed to keep family/enduring power of attorney (EPOA) informed with any change in the health status of the resident. The accident/incident form includes space for staff to document if family are kept informed following an adverse event. Family notification was missing in a selection of accident/incident reports reviewed. Interview with one family indicated that they were kept informed.</p>	<p>Notification of family/resident following an adverse event was missing in six of fifteen accident/incident reports reviewed (two medication errors, two pressure injuries, two skin tears).</p>	<p>Ensure documentation on the accident/incident form indicates family/resident being kept informed following an adverse event.</p> <p>90 days</p>
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	<p>Quality improvement data (eg, falls, skin tears, pressure injuries, medication errors, infections) is being collected, analysed and evaluated. Data is benchmarked against other Summerset facilities with targets established. Internal audits take place as per the audit schedule monthly. Missing is evidence of quality and risk data results being communicated to staff.</p>	<p>There are gaps in meeting minutes around the reporting of all quality data, trends and corrective actions.</p>	<p>Ensure staff are kept informed regarding the reporting and results of all quality data, trends and corrective actions.</p> <p>90 days</p>

<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	<p>PA Moderate</p>	<p>Corrective action plans have been established where internal audits reflect shortfalls. A corrective action plan was also put into place following the recent (2015) resident satisfaction survey. Missing is consistent evidence of corrective actions for quality data that exceeds targets and corrective action plans that result from complaints received (link 1.1.13.3). Also missing is evidence that corrective action plans are consistently implemented and evaluated.</p> <p>Since the draft report Summerset provided examples of specific action plans for both falls prevention and skin tears.</p>	<p>i) Corrective action plans are not routinely established where opportunities for improvements are highlighted and, ii) evidence supporting the implementation and the evaluation of corrective action plans that have been established are missing.</p>	<p>i) Ensure corrective action plans are consistently documented where improvements are required, and ii) ensure there is documented evidence to support the implementation and evaluation of all corrective action plans.</p> <p>60 days</p>
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	<p>PA Moderate</p>	<p>The adverse events reporting system is integrated into the quality and risk management programme. Hard copy accident/incident forms are completed by staff with electronic uploading of the form by the village manager. The hard copy accident/incident form reflects the clinical manager investigating accidents and incidents but the electronic version mistakenly reflects the village manager as being responsible for investigating adverse clinical events. Also, the electronic accident/incident form fails to identify staff designation. However there is another copy of the incident form in the resident file that identifies staff involvement and designation.</p> <p>Two complaints received in 2015 that were linked to adverse events did not have an associated accident/incident form completed.</p>	<p>i) Two significant events that resulted in complaints did not have an associated accident incident form completed. One event was related to a missed medication and the second event was related to a resident fall.</p> <p>ii) Electronic data input is being entered by the village manager with the village manager's electronic signature linked to the investigation. In addition, the electronic accident/incident form fails to include staff designation (eg, caregiver, registered nurse).</p>	<p>i) Ensure staff complete incident/accident forms for all adverse events as per the organisation's policies and procedures.</p> <p>ii) Ensure accident and incident investigations that are uploaded electronically indicate that a registered nurse is responsible for the investigation. Ensure electronic accident/incident forms include the involved staff</p>

				member(s) designation.  60 days
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	PA High	<p>The service uses an electronic medication management system. Medication shown as not given at the prescribed time had no information recorded to advise if this was given at a later date, and no reasons documented for the medication not being given and therefore it is unclear if it was given or not. There were no reports being generated and monitored by the service as available with the programme.</p>	<p>Medication shown as not given at the prescribed time had no information recorded to advise if this was given at a later date, and no reasons documented for the medication not being given and therefore it is unclear if it was given or not</p> <p>The recorded missed medication report showed 22 residents had missed a medication dose (including but not limited to Citalopram, frusemide, domperidone, pantoprazole, warfarin, simvastatin, nitroderm patch, oxybutynin, digoxin, morphine). The recorded missed medication report showed three residents had missed a short course medication (including erythromycin, and fluorouracil)</p>	<p>Ensure that all medication is administered as prescribed and an explanation is documented if a dose is missed. Ensure reports are generated to assist with monitoring this.</p> <p>7 days</p>
<p>Criterion 1.3.12.6</p> <p>Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail</p>	PA Moderate	<p>In the medication files reviewed the GP had prescribed all medication to be administered to the resident on admission. Not all 'indications for use' had been documented for "as required" medications</p>	<p>Eight of 10 medication charts did not have indications for use charted for PRN medication.</p>	<p>Ensure that all PRN medication has indications for use documented</p> <p>30 days</p>

to comply with legislation and guidelines.				
<p>Criterion 1.3.3.1</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.</p>	<p>PA Moderate</p>	<p>Registered nurses were responsible for the assessment, care planning and evaluation of residents care. Many of the registered nurses had been new to the service in the last year. On the day of audit the clinical information was not well organised and RNs could not always locate documentation. (Progress notes, assessments, GP reviews).</p>	<p>Processes and responsibilities for documentation were not being adhered to and clinical oversight and monitoring to ensure these were being fully completed was not established.</p>	<p>Ensure registered nurses are fully competent and supervised to ensure documentation and responsibilities are fully completed</p> <p>30 days</p>
<p>Criterion 1.3.3.3</p> <p>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.</p>	<p>PA Moderate</p>	<p>The registered nurses are responsible for assessments and development of the care plans. Not all long term care plans had been completed within the required time frames. The registered nurses and care staff write separate entries in the progress notes.</p>	<p>(i) The long term care plan's had not been developed within required timeframes in three of five files reviewed; (a) the care plan was developed five weeks after admission for one rest home resident in the serviced apartment, (b) the care plan was developed three months after admission for one hospital resident, and (c) and one rest home resident admitted in November 2015 had no long term care in place on day of audit.</p> <p>(ii) The InterRAI assessment was not completed for one rest home resident in the serviced apartment admitted in April 2015.</p> <p>(iii) One of one long term care plans</p>	<p>(i)-(ii) Ensure all residents have their long term care plan completed and in the required time frames.</p> <p>(iii) Ensure that InterRAI assessments are completed for all residents within required timeframes.</p> <p>(iv) Ensure all resident files evidence a three monthly GP review.</p>

			<p>due for review not been evaluated in the required timeframe.</p> <p>(iv) One of five files sampled had no evidence of a three monthly GP.</p>	30 days
<p>Criterion 1.3.3.4</p> <p>The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.</p>	PA Moderate	<p>A verbal and written handover occurs at the beginning of each shift where any issues or changes in resident status are discussed.</p> <p>Progress notes are maintained at least daily for rest home and each shift for hospital residents or more frequently as required. Not all resident files reviewed had daily entries in the progress notes. RNs write in the medical continuation notes at least weekly and with significant events.</p>	<p>(i) For one rest home resident in the serviced apartment the progress notes were not evidenced as completed on a daily basis (progress note gaps up to 18 days).</p> <p>(ii) A review of progress notes in all five files identified lack of follow through and integration. The registered nurses write progress notes in the medical notes. There is no link to the caregiver's progress notes. Examples include; (a) one hospital resident (tracer) who was not eating or drinking, (b) for one hospital resident who was documented as refusing care and had aggressive behaviour. The RN entry for the same day reported "settled no concerns".</p>	<p>(i) Ensure documentation complies with the organisational policy.</p> <p>(ii) Ensure progress notes are integrated and identify link and follow through of care.</p> <p>30 days</p>
<p>Criterion 1.3.4.2</p> <p>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</p>	PA High	<p>The RN's interviewed stated that all residents had been assessed using the InterRAI. The RN's on duty on the day of audit had not been trained in the use of the InterRAI and could not access the InterRAI information. The RN's reported they no longer completed pain assessments.</p> <p>The RN's undertake initial assessments on all wounds and pressure injuries and with each dressing change. Not all wound assessments were</p>	<p>(i) InterRAI information was not accessible on first day of audit and copies of InterRAI information was not available in the resident files sampled.</p> <p>(ii) The InterRAI assessment completed for one hospital resident (hospital tracer) on 13 December 2015 documents the worst pressure</p>	<p>(i) Ensure that InterRAI assessments are completed for all residents and the information is accessible to all registered nurses.</p> <p>(ii) Ensure that</p>

planning.		documented fully.	<p>injury as cracked skin, however the resident had three grade four pressure injuries and one grade one pressure injury insitu. at the time of the assessment. The assessment documented no falls in past 30 days; however two falls were documented in the progress notes within the 30 day assessment period.</p> <p>(iii) Pain assessments were not completed for i) one hospital resident with frequent reports of pain in the progress notes (hospital tracer), and one hospital resident following a fracture.</p> <p>(iv) Initial wound care assessments were not fully documented for all current pressure injuries, and current wounds.</p> <p>(v) On-going assessments were not fully documented with each dressing change for all current pressure injuries, and current wounds.</p>	<p>copies of the InterRAI assessment information/summary is placed on the resident file.</p> <p>(iii) Ensure that the InterRAI assessment information documented accurately reflects the assessments completed and the resident's care status/risks.</p> <p>(iv) Ensure that pain assessments are completed for residents in pain. (Since the draft report the provider has stated, pain assessments are incorporated as part of the Medi-Map documentation)</p> <p>(v) Ensure wound care assessments are documented for all wounds and ongoing assessments is completed at dressing changes</p> <p>7 days</p>
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<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA High</p>	<p>There was evidence of the use of short term care plans for wounds, and infections. However the care interventions required for acute changes in health condition, although noted to be documented in progress notes at times, were not always transferred to a care plan. Care requirements documented by allied health care professionals were not always transferred to the long term care plan.</p>	<p>(i) Five of seven files reviewed (sample increased) did not have care plans documented for acute changes in health condition (infections, wounds, challenging behaviour and pain management)</p> <p>(ii) Five of five care plans reviewed did not have interventions documented for all identified care needs. Example: management of the IDC, pain, skin integrity, weight loss, risk of choking, frequent urinary tract infections, end of life care, risk of falls, and care following surgery.</p> <p>(iii) One rest home resident with high risk of pressure injuries had no pressure prevention strategies documented</p> <p>(iv) Pressure injury interventions were not fully documented for three hospital residents with pressure injuries.</p> <p>(v) Short term care plans were not all evaluated or linked to the long term care plan for i) one hospital resident with high falls risk following a fracture, ii) one hospital resident with pressure injuries</p>	<p>(i) Ensure that care plans are documented for all acute changes in health condition.</p> <p>(ii) Ensure that interventions are documented for all assessed care needs</p> <p>(iii) &amp; (iv) Ensure pressure injury prevention strategies are documented</p> <p>(v) Ensure that all short term care plans are evaluated and signed out and or linked to the long term care plan.</p> <p>Since the draft report, Summerset has noted that they had already identified the issue and that there was a plan in place to upgrade care plans</p> <p>7 days</p>
<p>Criterion 1.3.5.3</p> <p>Service delivery plans demonstrate</p>	<p>PA Moderate</p>	<p>There was evidence that residents were referred to other members of the allied health care team including geriatric nurse specialist wound care specialist, dietitian, physiotherapist and speech and</p>	<p>Care requirements documented for a hospital resident in the progress notes by the geriatric nurse specialist (GNS) for care of an IDC,</p>	<p>Ensure that all care requirements documented in the progress notes are</p>

service integration.		language therapist. Care instructions documented in the progress notes by allied health care professionals were not always transferred to the care plan.	and by the wound care specialist nurse WCSN) for care of pressure injuries were not transferred to the LTCP, or the wound care plan.	transferred to the care plan.  30 days
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA High	Interventions were documented in the care plan for assessed care needs by the RN (link 1.3.4.2 and 1.3.5.2). Not all care requirements documented were implemented. Not all monitoring undertaken by the care staff was reviewed by the RN.	<p>(i) Interventions documented by the geriatric nurse specialist (GNS) for care of an IDC (monitoring of all input and output, trial routine catheter change and review by dietitian) were not evidenced as having been implemented (also link 1.3.5.2).</p> <p>(ii) Interventions documented by the wound care specialist nurse (WCSN) for care of pressure injuries (use of prescribed dressing and pressure relieving device) were not implemented (link hospital tracer).</p> <p>(iii) Residents on monitoring charts had no evidence of review by a RN. Examples include; (i) one rest home resident on a behaviour log, (ii) two hospital residents on food and fluid monitoring, and (iii) three residents on turning charts.</p> <p>(vi) Two-hourly turns were not documented as completed for one hospital resident (link hospital tracer) with pressure injuries</p> <p>(v) Monthly weighs were not consistently recorded for one hospital resident with weight loss (also link 1.3.5.2).</p>	<p>(i) &amp; (ii) Ensure all care requirements requested by allied health care professionals are implemented. Since the draft report, Somerset stated that the resident was on an air mattress and wound dressings were in place (although not the dressing requested as it was not on site).</p> <p>(iii) Ensure all monitoring charts completed by care staff are regularly reviewed by the RN as part of on-going assessment and follow up.</p> <p>(iv) Ensure all turning charts evidence that turns are completed within the required time frames.</p> <p>(v) Ensure that all</p>

			<p>(vi) Adequate dressing supplies were unavailable on site for one resident with a sacral pressure injury. The treatment record notes "no dressing supplies on site" on the wound treatment form on the date the dressing was due to be changed.</p>	<p>weights are consistently recorded and followed up.</p> <p>7 days</p>
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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, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display
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End of the report.