Summerset Care Limited - Summerset At Bishopscourt

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:

Legal entity:	Summerset Care Limited
Premises audited:	Summerset At Bishopscourt
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 19 February 2016 End date: 19 February 2016

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 42

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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 at Bishopscourt is able to provide hospital (geriatric and medical) and rest home level care for up to 42 residents in the care centre and 20 rest home residents in the serviced apartments. On the day of the audit there were 42 residents. The service is managed by a village manager and a care centre nurse manager. The village manager and nurse manager are well qualified for their roles. They are supported by a regional operations manager, registered nurses and care staff. The residents and family 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, management, general practitioner and staff.

The service has addressed 10 of 14 previous findings from the certification audit relating to meeting minutes, corrective action plans, assessments, activities, self-medicating residents, restraint consent, assessment, monitoring and the restraint register, and infection surveillance.

Further improvements are required in relation to collection of quality data, timeframes for completion of care planning, care plan documentation and interventions.

Consumer rights

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

Residents and families are kept informed on all aspects of the service and resident health. Residents and their family are provided with information on the complaints process on admission. Complaints are being managed in a timely manner. Staff are aware of the complaints process and to whom they should direct complaints.

Organisational management

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

The village manager is responsible for the day-to-day operations of the facility with the nurse manager responsible for the clinical care of the residents. The nurse manager has been in the role since October 2015 and is an experienced registered nurse. She has completed Summerset management orientation. Summerset quality management processes are reflected in organisational and service business plans, goals and objectives and policies. A risk management programme is in place, which includes a risk management plan, incident and accident reporting and health and safety processes. Incidents and accidents are documented by staff.

Residents receive appropriate services from suitably qualified staff. Recruitment is managed in accordance with good employment practice and meeting legislative requirements. An orientation programme is in place for new staff with ongoing education and training provided.

There are adequate numbers of staff on duty to ensure residents are safe. Registered nurses are employed to cover each shift.

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.

InterRAI assessments and comprehensive paper based assessment tools are used on admission and thereafter. Assessments, care plans and care plan evaluations are completed by registered nurses. A diversional therapist and recreation assistant plan and implement an integrated activity programme. There are outings into the community and visiting entertainers. The medication system meets legislative requirements. The service uses an electronic medication management system. The food service is contracted to an external company who provide food services on site. Resident's individual dietary needs were identified and accommodated.

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.

The service displays a current building warrant of fitness.

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.

There are documented and implemented policies and procedures around restraint use and use of enablers. There was restraint in use for one resident and one enabler. Restraint audits, training and competencies for staff have been completed.

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.

The infection control programme and its content and detail was appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator (registered nurse) monitors infection rates. Surveillance activities include audits of the facility, hand hygiene and surveillance of infection control events and infections. Staff receive on-going training on infection control. Outbreaks are appropriately managed.

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	17	0	2	2	0	0
Criteria	0	41	0	1	3	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	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. Residents confirmed their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints. There is an electronic complaints register that includes verbal and written complaints. There is evidence to confirm that the complaints received in 2015 and two in 2016 have been managed in a timely manner, including acknowledgement, investigation, time lines, and corrective actions when required and resolutions. HealthCERT requested follow up against aspects of a complaint lodged in 2015 through the Health and Disability Commissioner that included management of the complaints process and cleaning and laundry services provided by the service. The service has made improvements in the areas of complaints management and cleaning and laundry services. Internal audits of cleaning and laundry are conducted and discussion with staff has been held to ensure improvements in systems and processes around cleaning and laundry are maintained. Laundry procedures have been altered to ensure an improved standard. Residents and families interviewed advised that the facility is well maintained, the care centre and apartment areas are cleaned regularly and laundry services are satisfactory.

Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	An open disclosure policy describes ways that information is provided to residents and families. The admission pack gives 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. An interpreter is provided as required. Regular contact is maintained with family including if an incident or care/health issues arises as documented on accident/incident forms sampled and family consultation record in the resident files. Two hospital relatives and eight residents (six rest home and two hospital) stated they were well informed. There are monthly residents meetings where any issues or concerns to residents are able to be discussed. Newsletters are sent out to families. Interpreter services can be accessed as required.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	The service provides care for up to 62 residents at hospital (geriatric and medical) and rest home level care. On the day of the audit, there were 42 residents in total - 21 residents at rest home level (two are in the serviced apartments) and 21 residents at hospital level including one receiving palliative care and two on ACC contracts. There were no respite residents and no residents under the medical component. The two hospital level residents on ACC contracts are under the age of 65. The remaining residents were under the aged related contract. The Summerset Group Limited Board of Directors have overall financial and governance responsibility and there is a company strategic business plan in place. Summerset at Bishopscourt has a site specific business plan and goals that are developed in consultation with the village manager, nurse manager and regional operations manager (ROM). The Summerset at Bishopscourt quality plan is reviewed regularly throughout the year. There is a full evaluation at the end of the year. The 2015 evaluation was sighted. The village manager (non-clinical) has been in the current role at Summerset for two years and has attended at least eight hours of leadership professional development relevant to the role. The village manager is supported by a nurse manager. The nurse manager has been in the role for four months and has a background in aged care, palliative care and nurse tutoring.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and	PA Low	A quality and risk management plan is in place. 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 are responsible for policy implementation as directed from head office. The monthly collating of quality and risk data includes (but is not limited to) residents' falls, infection rates

risk management system that reflects continuous quality improvement principles.		and pressure areas. Data is collated and benchmarked against other Summerset facilities to identify trends and quality improvements. Not all incident reports for December 2015 had been entered on to the Summerset software (SWAY – Summerset Way). A care satisfaction survey is conducted annually. Results for 2015 show an overall satisfaction rate of 87%. An analysis and action plan has been developed for identified areas for improvement. Residents and families have been informed of the survey outcomes at the October 2015 resident meeting. The service has made improvements in this area in respect to a previous finding. The service completes internal audits as per the annual audit programme. Corrective actions have been developed for all opportunities for improvements identified through quality activities. Meeting minutes have a corrective action format and these were noted to have been implemented and signed off when completed. The service has addressed these previous findings. Staff are informed of audit findings and quality initiatives through the quality improvement meetings and staff meetings. Falls prevention strategies are in place that include the identification of interventions on a case-by-case basis to minimise future falls. The health and safety programme is overseen by the village manager who has completed stage one and two health and safety training. Health and safety discussion and quality data is incorporated into the monthly quality improvement meetings (minutes sighted). Staff complete hazard identification forms for identified/potential hazards. A current hazard register is in place.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	The service collects a comprehensive set of data relating to adverse, unplanned and untoward events (link #1.2.3.6). This includes the collection of incident and accident information reported by staff on a paper based system. The reporting system is integrated into the electronic quality and risk management programme (SWAY – Summerset Way). Incidents and accidents are reported on the incident forms. The registered nurses were notified in a timely manner as evidenced in the progress notes and accident/incident form on the 13 forms viewed in resident files. The incidents forms are then reviewed and investigated by the nurse manager or village manager as required. If risks are identified, these are processed as hazards. Discussions with the village manager and nurse manager confirmed their awareness of statutory requirements in relation to essential notification. There has been one outbreak since the previous audit and one essential notification under section 31 of the Ministry of Health.
Standard 1.2.7: Human Resource Management	FA	There are job descriptions available for all relevant positions that describe staff roles, responsibilities and accountabilities. Practising certificates reviewed were current. Six staff files were reviewed (the nurse manager, the clinical nurse leader, one registered nurse, two caregivers and one recreational therapist).

Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.		Evidence of signed employment contracts, job descriptions, orientation and training were in the files reviewed. Annual performance appraisals have been conducted for all staff as they fall due. Newly appointed staff complete an orientation that is specific to their job description. Care staff interviewed described the orientation programme that includes a period of supervision. The service has an annual training schedule for in-service education that links with policy reviews, internal audits, Careerforce modules and on-line training. External training is available for RNs. The education has been implemented and attendance recorded. Staff members who are unable to attend education are required to read the education notes. The service has a company Careerforce assessor. Staff complete competencies relevant to their roles. Registered nurses are trained and competent in the use of the interRAI assessment tool.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. The village manager and nurse manager work full-time Monday to Friday. There are registered nurses rostered on to provide cover 24/7. There is sufficient staff rostered on to provide care to rest home, hospital and serviced apartment residents. There are at least three staff members (one registered nurse and two caregivers) on duty at the care centre at all times. Staff reported that staffing levels and the skill mix was appropriate and safe. Residents and family interviewed advised that they felt there was sufficient staffing.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	The service medication management system follows recognised standards and guidelines for safe medicine management practice in accordance with the Medicines Care Guide for Residential Aged Care 2011. The service uses electronic medication management system and review of 10 medication charts revealed that medication management system is appropriately implemented. Medications are supplied monthly or as required. Only medicine competent registered nurses administer medication. There are three medicine competent carers who administer medicine in the serviced apartments. On the day of audit there were no residents self-administering medication. Staff interviewed confirmed that self-medication management system is reviewed and they are aware of requirement around self-medication assessment and monitoring. The previous audit finding has now been addressed. Medication fridge temperatures are monitored. The service documents adverse reactions and errors on incident/accident forms. There are four syringe drivers and staff maintained syringe driver competencies through Otago Community Hospice. Medications are managed appropriately in line with accepted guidelines. A medication round observed at lunch time evidenced safe and correct administration of

		medication.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	The service has a large kitchen and equipment is well maintained. Food services are contracted to an external company. There is a four week rotating menu approved by the dietitian. Special diets are catered for and documented in the kitchen. Food safety information and a kitchen manual are available. Food served on the day of audit was hot and well presented. The service encourages residents to express their likes and dislikes. The residents interviewed said that they enjoyed meals and they get asked by staff about their food preferences. Equipment is available on an as needed basis. Residents requiring extra support to eat and drink are assisted and this was observed during lunch. Fridge/freezer and food temperatures are checked daily. The kitchen was clean and all food was stored off the floor. Chemicals were locked away. The residents have a nutritional profile developed on admission by a registered nurse who identifies dietary requirements and likes and dislikes. Five files reviewed had up to date nutritional documentation and a copy was maintained in the kitchen. All family members and residents interviewed expressed satisfaction with the meals. Staff working in the kitchen have food handling certificates.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Initial assessments were accurately completed in all resident files sampled at the time of admission. This is an improvement since the previous audit. The service uses the interRAI assessment tool however, not all assessments were up to date (link#1.3.3.3) and not all files yet had current interRAI assessments. There are other clinical assessment tools that have been utilised on admission and thereafter as required. Review of these assessments showed that interRAI assessments process is being followed up and reflected residents' current needs. Assessment notes were comprehensive and included interviews with resident, family and other health professionals. Behaviour assessments were completed as required. The service has addressed this aspect of the previous finding.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Low	Four out of five files reviewed showed that long term care plans were comprehensive and demonstrated service integration and input from allied health. These care plans had given clear direction to staff and were reflected in the progress notes. Medical notes, allied health professionals recordings, significant events and communication with families were well documented. The previous audit finding remains an improvement.

Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Moderate	Palliative care is provided with support from Otago Community Hospice. The service has developed a palliative care plan which is based on the current best practice. On the day of the audit, one resident was receiving palliative care. A document review and interview with three caregivers, nurse manager and a family member confirmed that the resident's palliative care needs were met and the family was well supported. Referrals to the stoma nurse, wound specialist and a psychologist were sighted in the files reviewed. There is a contract with a physiotherapist and podiatrist. Interview with one GP evidenced that care provided is of a high standard and GPs are kept informed. Family members agreed that care is provided consistent with their resident's needs and that they were involved in the care planning. Care staff interviewed stated that there is adequate equipment provided including continence and wound care supplies. Wound assessment, wound management and evaluation forms were in place for two minor wounds. Wound management and monitoring occurred as planned. All have appropriate care documented and provided, including pressure relieving equipment. Wound care plans were in place for all pressure injuries and wounds and the wound care plans included assessments, plans and evaluations. Pressure injury prevention activities were implemented including the use of pressure relieving devices, turning charts, audits, education for staff and policies and procedures specific to pressure injury prevention. Access to specialist advice and support are available as needed. Care plans documented allied health input. Resident's weight is monitored at least monthly and one file reviewed included more frequent monitoring of the resident's weight as instructed by the GP. This aspect of the previous audit finding has been addressed. Further improvement is required around implementation of specialist's recommendations.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	The service employs a diversional therapist and a recreation assistant. They both work four on four off and provide weekend cover. Review of five files and interview with the diversional therapist confirmed that activity assessments and plans were completed within the required timeframes. Residents' activity program attendance was maintained. All required documentation around planned activities was up to date. There is a monthly programme that covers a seven-day week. The service has a wheelchair van utilised for outings each week. Community links such as library, SPCA visits, gallery visits and walks within the village. Church services are held onsite twice a month. One on one contact is made with residents who are unable or choose not to participate in group activities. Resident and family interviewed confirmed this. The service has addressed this previous audit finding.

Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	All initial care plans were developed and evaluated by the registered nurses. There is a three monthly review by the GP. In three out of five files reviewed showed that care plan evaluations were completed at least six monthly and the two files evidenced less frequent reviews (link# 1.3.3.3). Overall changes in health status were documented. The resident's own GP reviews resident's medication at least three monthly or when requested if issues arise or health status changes. Short term care plans were sighted for wounds, infections, falls and nutritional needs.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The service displays a current building warrant of fitness that expires on 5 May 2016.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Infection monitoring is the responsibility of the infection control coordinator (registered 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. 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 quality improvement meetings which includes infection control. Recommendations for improvements are documented and followed through. The service has addressed this previous finding. Infection control is discussed at management meetings, clinical meetings and staff handovers. Organisational benchmarking occurs against facilities of similar size. There has been one outbreak reported since the previous audit. Appropriate management and notification was implemented. A debrief meeting was held with all staff and improvements have been identified.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	There are policies around the use of restraints and enablers which align with the standard. The nurse manager is the restraint coordinator. There is one hospital level resident with a bed rail and lap belt restraint and one rest home resident with a bedrail enabler. Staff have received training around restraint minimisation, the management of challenging behaviour and completed restraint competencies. Enablers are voluntary. Both resident files were reviewed and evidenced that both restraints and enablers are managed with the same documentation.

Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.	FA	Responsibilities and accountabilities for restraint are outlined in the restraint coordinators job description. The nurse manager is the restraint coordinator. A restraint review report is provided to the monthly quality meetings. 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. The one hospital level resident with bed rails and a lap belt restraint evidenced consent forms completed prior to the commencement of the restraint. The service has addressed this previous finding.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	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. One restraint file reviewed documented an in-depth assessment including the consideration of alternatives and this was competed prior to the application of restraint. The service has addressed this previous finding.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	Restraint policy states that the need for restraint use is monitored and reviewed as part of the six monthly reviews. Restraints have been evaluated monthly by the restraint coordinator (nurse manager). 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 also 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 maintained by the restraint coordinator. Restraint monitoring has been documented with two hourly monitoring recorded for when the bedrails are insitu and half hourly for when the lap belt is in place. The service has addressed these previous findings.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	Quality improvement activities include completion of the internal audit schedule, feedback from residents, families and staff via complaints and surveys, complaints process and incidents and accidents. Incident reports are completed by care staff and registered nurses and are then reviewed by the nurse manager. The incident data is then entered on to a Summerset data base (SWAY). On review of the previous three months, it was noted that not all incident report forms have been entered on to the data base.	Data relating to 17 incident reporting forms for December 2015 has not been collected or entered on to the SWAY data base.	Ensure that all incident reports are collated and analysed to identify opportunities for improvement. 90 days

Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Moderate	Care plan documentation is still in progress. InterRAI assessments were not completed as required for some residents. Three out of five files reviewed showed that interRAI assessments were up to date. Initial care plan documentation is completed within 24 hours of admission. Long term care plans were completed within 21 days of entry to the service in three out of five files reviewed. Three of five files evidenced that care plan evaluations were completed six monthly.	i) Two out of five files reviewed did not have interRAI assessments completed within 21 days of admission. Interview with the clinical nurse lead, the nurse manager and a RN confirmed that interRAI has not been utilised for all residents; ii) Two out of five files reviewed showed that long term care plans were not developed within 21 days of admission; iii) Two out of five files revealed that interRAI assessments were completed after the care plan documentation was completed. Care plan review has not been documented ensuring that interRAI informs the long term care planning; and iv) two of five files evidenced that care plan evaluations were not completed six monthly.	i)Ensure that interRAI assessments are completed within 21 days of admission; ii) Ensure that long term care plans were developed within the 21 days of admission; iii) Ensure that interRAI assessments inform the care planning process; and iv) Ensure that care plan evaluation occurs at least six monthly. 60 days
Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes	PA Moderate	Four of five files reviewed showed that care plan interventions were well described and reflected resident's current needs. One file reviewed included behaviour management plan, triggers and de-escalation techniques. Since the previous audit, physiotherapist documentation has been changed. Clinical	A rest home level resident was prescribed an anticoagulant medication. The residents' care plan interventions did not include the risks related to this medication.	Ensure that care plan interventions address all assessed risk and identified problems. 60 days

identified by the ongoing assessment process.		nurse leader and registered nurses ensure that physio assessments and mobility plans are included in the short term and long term care plans. Residents' weights were monitored and recorded in the resident file. Interview with three caregivers, one registered nurse and the nurse manager confirmed that there was no resident with unintentional weight loss. These aspects of the previous findings have been addressed.		
Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Moderate	Five resident files reviewed showed that three out of five files included documentation that meets the needs of the resident and all care plans had been updated as residents` needs changed. One file reviewed did not have risk management of anticoagulant medication in the care plan interventions (link# 1.3.5.2.). Another file reviewed had recommendations from the specialist service but these were not followed up.	Review of one file (hospital) showed that recommendation from a specialist service around wound care management related to pressure injury stage IV has not been followed up. This includes type of dressing to be used and frequency of dressing changes. The service had contacted a wound products specialist to review the wound to offer alternatives which was completed two days prior to this audit. However, this recommendation has also not been implemented yet (link hospital tracer #1.3.3). Another resident (rest home) required a further iron test within a month of discharge from the public hospital. Five weeks after discharge from the public hospital, this was not organised. The registered nurse and the nurse manager were interviewed and both were not aware of this recommendation. After discharge from the public hospital, the resident was seen by the GP but no comment has been made regarding this recommendation in the clinical notes.	Ensure that specialist recommendations are followed up. 60 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.