

# Summerset Care Limited - Summerset Mountain View

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## Introduction

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

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

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

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

The specifics of this audit included:

<b>Legal entity:</b>	Summerset Care Limited
<b>Premises audited:</b>	Summerset Mountain View
<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: 22 August 2016 End date: 23 August 2016
<b>Proposed changes to current services (if any):</b>	
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	29



# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

## General overview of the audit

Summerset Mountain View provides rest home and hospital (medical and geriatric) level care for up to 36 residents in the care centre and up to eight residents at rest home level in the serviced apartments. On the day of the audit, there were 29 residents. The residents and relatives interviewed spoke positively about the care and support provided.

This certification audit was conducted against 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, staff and a general practitioner.

The village manager is appropriately qualified and experienced and is supported by a nurse manager (registered nurse) who oversees the care centre.

The new facility has been operational since December 2015 and quality systems are not yet fully established and implemented.

Improvements are required around the complaints register, quality improvement meetings and quality data, internal audits and corrective actions, hazard register, training programme, resident-centred care plans, interventions, prescribing of oxygen and restraint assessments.

## 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.		Some standards applicable to this service partially attained and of low risk.
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Summerset Mountain View provides care in a way that focuses on the individual resident. There is a Māori health plan and cultural safety policy supporting practice. Cultural assessment is undertaken on admission and during the review process. The service functions in a way that complies with the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and related services is readily available to residents and families. Policies are available that support residents' rights. Care plans accommodate the choices of residents and/or their family. A complaints procedure is provided to residents within the information pack at entry. Residents and family interviewed verified ongoing involvement with the community.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Summerset Mountain View is implementing the organisation's quality and risk management system. There are policies and procedures being implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant

standards. There is an annual education/training plan, and meeting and audit plan. Summerset Mountain View has a site-specific business plan and goals. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is a staffing policy in place. There is a health and safety, and risk management programme in place.

## Continuum of service delivery

<p>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.</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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Resident's needs and level of care are assessed prior to entry. There is a well-developed information pack available for residents and families/whānau at entry. Assessments, resident-centred care plans and evaluations were completed by the registered nurses within the required timeframes. The InterRAI assessment tool is utilised. Resident centred care plans evidenced resident/family involvement and demonstrated allied health professional input into the resident's care.

A diversional therapist in training coordinates and implements an integrated activity programme. She is supported by a village recreational therapist. The activities meet the individual recreational needs and preferences of the resident groups. There are outings into the community and visiting entertainers.

There are medicine management policies in place that meets legislative requirements. Staff responsible for the administration of medications complete annual medication competencies and education. The general practitioner reviews the medication charts three monthly.

The food service is contracted to an external company. The menu has been reviewed by a dietitian. Resident's individual dietary needs were identified and accommodated. Staff have attended food safety and hygiene training.

## 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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There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Chemicals are stored safely throughout the facility. The building has a current code of compliance. There is a reactive and planned maintenance schedule in place. Resident bedrooms are spacious and personalised. There are bedrooms with en-suites and some without that are closely located to communal toilet/showers. There was sufficient space to allow the movement of residents around the facility using mobility aids or lazy boy chairs. The hallways and communal areas were spacious and accessible. The outdoor areas are safe and easily accessible and provide seating and shade. The service has implemented policies and procedures for civil defence and other emergencies and six monthly fire drills are conducted. There is a first aid trained staff member on every shift. Summerset Mountain View has an approved fire evacuation plan and fire drills have occurred six monthly. Housekeeping/laundry staff maintain a clean and tidy environment. There is plenty of natural light in all rooms and the environment comfortable with adequate ventilation and heating.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Some standards applicable to this service partially attained and of low risk.
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Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort. The restraint coordinator maintains a current register and reviews restraint use three monthly. Staff receive regular education and training on restraint minimisation. There were four restraints in use on the day of audit.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection control programme is appropriate for the size and complexity of the service. The infection control officer (registered nurse) is responsible for coordinating and providing education and training for staff. The infection control officer has attended external training. The infection control manual outlined the scope of the programme and included a comprehensive range of policies and guidelines. The infection control officer uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This included audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Somerset facilities.

## 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)
<b>Standards</b>	0	43	0	4	3	0	0
<b>Criteria</b>	0	92	0	6	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Discussions with staff (eight care assistants, three registered nurses (RN), one diversional therapist and one recreational therapist) confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Five residents (all rest home) and three relatives (two hospital and one rest home) were interviewed and confirmed the services being provided are in line with the Code. Observation during the audit confirmed this in practice.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Informed consent processes were discussed with residents and families on admission. Written general and specific consents were evident in the six resident files reviewed (two hospital, four rest home level of care including one respite care resident and one resident funded by ACC). Caregivers and registered nurses interviewed confirm consent is obtained when delivering cares. Resuscitation orders had been appropriately signed by the resident and general practitioner. The service acknowledges the resident is for resuscitation in the absence of a signed directive by the resident. The general practitioner (GP) had discussed resuscitation with families/enduring power of attorney (EPOA) where the resident was deemed incompetent to make a decision.  Discussion with family members (two hospital and one rest home) identifies that the service actively involves them in decisions that affect their relative's lives. Six admission agreements sighted were all

		signed.
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	Residents are provided with a copy of the Code on entry to the service. Residents interviewed confirmed they are aware of their right to access independent advocacy services and advocacy pamphlets are available at reception. Discussions with relatives confirmed the service provided opportunities for the family/enduring power of attorney (EPOA) to be involved in decisions. The resident files include information on residents' family/whānau and chosen social networks.
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. Activities programmes included opportunities to attend events outside of the facility including activities of daily living, for example, shopping and attending cafes and restaurants. Interview with staff, residents and relatives informed residents are supported and encouraged to remain involved in the community and external groups. Relative and friends are encouraged to be involved with the service and care.
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	PA Low	The organisational complaints policy states that the village manager has overall responsibility for ensuring all complaints (verbal or written) are fully documented and investigated. The Summerset group has a complaints procedure available for facilities to utilise that includes relevant information regarding the complaint. Summerset Mountain View did not have a complaints register in place. There was no documented evidence that any resident/family complaints made since the care centre opened in December 2015 were documented and entered into Sway ("The Summerset Way"). A complaints procedure is provided to residents within the information pack at entry. Feedback forms are available for residents/relatives in various places around the facility.
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	The service provides information to residents that include the Code, complaints and advocacy. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Residents and relatives interviewed identified they are well informed about the Code of Rights. Advocacy and Code of Rights information is included in the information pack and is available at reception.

<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Staff interviewed were able to describe the procedures for maintaining confidentiality of resident records, resident's privacy and dignity. House rules and a code of conduct are signed by staff at commencement of employment. Contact details of spiritual/religious advisors are available. Resident files include cultural and spiritual values. Residents and relatives interviewed reported that residents are able to choose to engage in activities and access community resources. There is an elder abuse and neglect policy. Staff education and training on abuse and neglect last occurred in July 2016.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>Summerset has a Māori health plan that includes a description of how they achieve the requirements set out in the contract. There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. On the day of the audit there were no residents that identified as Māori.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>An initial care-planning meeting is carried out where the resident and/or whānau as appropriate are invited to be involved. Individual beliefs or values are further discussed and incorporated into the resident-centred care plan. Six monthly multi-disciplinary team meetings occur to assess if needs are being met. Family are invited to attend. Discussion with relatives confirms values and beliefs are considered. Residents interviewed confirm that staff take into account their culture and values.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Staff job descriptions include responsibilities and staff sign a copy on employment. Management provide guidelines and mentoring for specific situations. Interviews with the village manager, nurse manager, registered nurses and care assistants confirmed an awareness of professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>Residents and relatives interviewed spoke positively about the care and support provided. Staff have a sound understanding of principles of aged care and state that they feel supported by the village manager and nurse manager. All Summerset facilities have a master copy of policies, which have been developed in line with current accepted best practice and are reviewed regularly. The content of policy</p>

		and procedures are sufficiently detailed to allow effective implementation by staff. Services are provided at Summerset that adheres to the Health & Disability services standards. There are implemented competencies for care assistants and registered nurses including but not limited to insulin administration, medication and manual handling.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents and family members stated they were welcomed on entry and given time and explanation about services and procedures. Family members interviewed also stated they are informed of changes in the resident's health status and incidents/accidents. Resident/relative meetings are scheduled to be held every four months with an advocate from Age Concern present at the meeting. This has occurred intermittently. Incident forms reviewed identified family had been informed following an incident. The village manager and the nurse manager have an open door policy. The service produces a newsletter for residents and relatives. Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The service has policies and procedures available for access to interpreter services for residents (and their family/whānau). If residents or family/whānau have difficulty with written or spoken English, the interpreter services are made available.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	<p>The service provides care for up to 36 residents at hospital (geriatric/medical) and rest home level care. On the day of the audit, there were 29 residents in total. There were 23 residents at rest home level (including one respite care resident and one ACC funded resident) and six residents at hospital level. All rooms are dual-purpose rooms. There were no younger people or residents under the medical component of the certification. All other residents were under the ARC contract. There are eight certified serviced apartments with seven currently unoccupied and one occupied by a rest home level resident. The service was opened December 2015. The Summerset Group Limited Board of Directors have overall financial and governance responsibility and there is a company strategic business plan in place.</p> <p>Summerset Mountain View has a site-specific business plan and goals that is developed in consultation with the village manager, nurse manager and regional operations manager (ROM). The Summerset Mountain View quality plan is reviewed regularly throughout the year. There is a full evaluation at the end of the year. The village manager has been in the current role at Summerset since October 2014 and was previously in the banking industry for 30 years. A nurse manager supports the village manager. The nurse manager has been in the position for three months and has a background in aged care nursing. All Summerset village managers and nurse managers attend annual organisational forums and regional forums over two days. The village manager and nurse manager attends clinical education and forums/provider meetings at the Taranaki District Health Board. There is a regional operations manager who is available to support the facility and staff. The village manager has attended</p>

		at least eight hours of leadership professional development relevant to the role.
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	During a temporary absence, the nurse manager will cover the village manager's role. The regional operations manager and the clinical quality manager provide oversight and support.
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	PA Moderate	<p>Summerset Mountain View is a documented quality and risk management system. There are policies and procedures being implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed on a regular basis. The content of policy and procedures are detailed to allow effective implementation by staff.</p> <p>The Summerset group has a 'clinical audit, meeting, training and compliance' calendar. The calendar schedules the meeting, training and audit requirements for the month. The 2016 internal audit schedule has not always been followed at Summerset Mountain View. Issues arising from internal audits are developed into corrective action plans. Not all corrective actions have been documented as followed up and completed. Monthly quality improvement meetings are part of the annual calendar that includes discussion about clinical indicators (eg, incident trends, infection rates). There have been no quality improvement meetings (including health and safety, infection control and restraint) completed for the period from January to July 2016.</p> <p>The Summerset group has a data tool "Sway- the Summerset Way". Monthly and annual analysis of results is completed and provided across the organisation through Sway, which is integrated and accommodates the data entered. There has been no clinical/quality data and benchmarking analysis discussed at Summerset Mountain View in 2016 year to date. There is a documented health and safety and risk management programme in place, however there is no current hazard register. The property manager is the health and safety officer (interviewed). Falls prevention strategies are in place that includes the identification of interventions on a case-by-case basis to minimise future falls. The first annual residents/relative's satisfaction survey is due to be sent out in late November or early December 2016.</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>	FA	<p>Incident and accident data has been collected and analysed (link 1.2.3.6). Fourteen resident related incident reports for July and August 2016 were reviewed (ten falls, two skin tears, one pressure injury and one challenging behaviour). All reports and corresponding resident files reviewed evidence that appropriate clinical care has been provided following an incident. The incident reporting policy includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Discussions with the service confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications.</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>	PA Low	<p>There are human resources policies to support recruitment practices. A list of practising certificates is maintained. Five staff files (one nurse manager, one RN, one recreational therapist and two care assistants) were reviewed and all had relevant documentation relating to employment. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme includes documented competencies and induction checklists (sighted in files of newly appointed staff). Staff interviewed were able to describe the orientation process and believed new staff were adequately orientated to the service.</p> <p>There is an annual education/training plan that is outlined on the 'clinical audit, training and compliance calendar'. The 2016 education/training calendar schedule has not always been followed to ensure all training topics have been completed as per the calendar schedule. A competency programme is in place with different requirements according to work type (eg, care assistants, registered nurse and kitchen). Core competencies are completed and a record of completion is maintained on staff files. Staff interviewed were aware of the requirement to complete competency training. Care assistants are supported to complete an NZQA aged care qualification.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>The village manager and nurse manager work 40 hours per week (Monday to Friday) and are available on call for any emergency issues or clinical support. The service provides 24-hour RN cover. The RNs are supported by four care assistants on morning shifts, three on the afternoon shifts and three on night shifts. A staff availability list ensures that staff sickness and vacant shifts are covered. Care assistants interviewed confirmed that staff are replaced. As from 1 August 2016, there has been one care assistant rostered on each shift in the serviced apartments. Staffing levels and skills mix policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery.</p>

<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident files reviewed are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access by being held in a locked cupboard. Care plans and notes reviewed were legible and where necessary signed (and dated) by a registered nurse. Entries are legible, dated and signed by the relevant care assistant or registered nurse including designation. Individual resident files demonstrate service integration.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>All residents have a needs assessment completed prior to entry that identifies the level of care required. The nurse manager screens all potential enquiries to ensure the service can meet the required level of care and specific needs of the resident.</p> <p>Residents (five rest home) and relatives interviewed stated that they received sufficient information on admission and discussion was held regarding the admission agreement. The admission agreement reviewed aligns with a) -k) of the ARC contract.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>An exit, discharge and transfer policy describes guidelines for death, discharge, transfer, documentation and follow-up. All relevant information is documented and communicated to the receiving health provider or service. Follow-up occurs to check that the resident is settled or, in the case of death, communication with the family is made.</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 Low	<p>There are medicine management policies and procedures that align with recognised standards and guidelines for safe medicine management practice in accordance with the Medicines Care Guide for Residential Aged Care 2011. RNs are responsible for the administration of medications in the rest home/hospital care centre. Senior care assistants complete competencies for the checking and witnessing of medications as required. Medication competencies and education has been completed annually. All medications were evidenced to be checked on delivery with any discrepancies fed back to the supplying pharmacy. The service uses an electronic medication system for long-term residents and short-term residents. Standing orders are not used. There were three rest home residents self-medicating on the day of audit. Self-medicating competency had been completed and signed by the resident, GP and RN. Self-medication competencies are reviewed three monthly. All medications are stored correctly. The medication fridge is monitored weekly.</p>

		<p>Ten resident medication charts on the electronic medication system and two paper-based medication charts were reviewed (four hospital and eight rest home). The charts had photograph identification and allergy status recorded. Staff recorded the time and date of 'as required' medications. All 12 medication charts reviewed identified that the GP had reviewed the medication chart three monthly. One resident on oxygen therapy did not have this charted on the medication chart.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>An external company is contracted for the provision of meals on-site. There is an eight-week rotating menu approved by the dietitian. The menu includes resident preferences. The chef manager (interviewed) is notified of any changes to residents' dietary requirements. Resident likes/dislikes and preferences are known and accommodated with alternative meal options. Special dietary requirements include pureed meals, lactose intolerant and food allergies. A food allergy declaration is listed for all café foods. The chef manager serves meals from the bain-marie in the dining room kitchenette. Special requests and alternative meals are plated and labelled. Texture modified meals and high protein drinks and foods are provided. The cook receives a dietary profile for each resident.</p> <p>The fridge and freezer temperatures are taken and recorded. End cooked food temperatures are recorded twice daily. All foods are stored correctly and date labelled. Cleaning schedules are maintained. Chemicals are stored safely within the kitchen. Staff were observed wearing correct personal protective clothing when entering the kitchen. The chemical provider completes a functional test on the dishwasher monthly.</p> <p>Staff working in the kitchen have food handling certificates and chemical safety training. A council certificate was received 9 June 2016.</p> <p>Residents commented positively on the meals provided. The chef manager receives feedback from resident meetings and welcomes suggestions on the meal service.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>The reason for declining service entry to potential residents should this occur, is communicated to the resident or family/whānau and they are referred to the original referral agent for further information.</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>FA</p>	<p>The initial support plan is developed with information from the initial assessment. Clinical risk assessments are completed on admission where applicable and reviewed six monthly as part of the InterRAI assessment. Outcomes of risk assessment tools are used to identify the needs, supports and interventions required to meet resident goals. The InterRAI assessment tool has been utilised for all long-term residents.</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 Moderate</p>	<p>Resident-centred care plans describe the individual support and interventions required to meet the resident goals. Not all care plans in the files reflected the outcomes of risk assessment tools or the current health status of the resident. Care plans demonstrate service integration and include input from allied health practitioners.</p> <p>Short-term care plans were sighted for changes in health status such as wounds and infections. Short-term care plans are either resolved or if an ongoing problem, added to the long-term resident-centred care plan.</p> <p>There is documented evidence of resident/family involvement in the care planning process. Residents/relatives interviewed confirmed they participate in the care planning process.</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 Moderate</p>	<p>When a resident's condition changes, the RN initiates a review and if required, a GP, or nurse specialist consultation. Relatives interviewed state their relative's needs are met and they are kept informed of any health changes. There was documented evidence in the resident files of family notification of any changes to health including infections, accidents/incidents, and medication changes. Residents interviewed state their needs are being met.</p> <p>Adequate dressing supplies were sighted. Initial wound assessments with ongoing wound evaluations and treatment plans were in place for five residents with wounds (including one chronic ulcer and one surgical wound). There were no pressure injuries on the day of audit. The nurse manager confirmed there was access to a wound nurse specialist available as required.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed.</p> <p>A shortfall was identified around interventions and monitoring requirements.</p>

<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The service employs a recreational therapist (RT in DT training) for 30 hours per week in the care centre and an RT for the village 5.5 hours per day. The activity team have monthly Summerset conference calls and annual conference for all RTs and DTs. Both activity persons have current first aid certificates.</p> <p>The integrated rest home and hospital programme covers five days a week. The programme is planned a month in advance and includes set Summerset activities with the flexibility to add other activities of interest or suggestions made by residents. Activities meet the recreational needs of both resident groups ensuring all residents have the opportunity for outings, shopping, and attending community groups/events including concerts and functions. Community links are maintained with visiting entertainers and speakers, Tai Chi, library bus and pastoral visitors (for church services and one-on-one chats with residents). Gender events are held such as men's breakfast and ladies high tea. The village programme is open to all residents to attend.</p> <p>The service has a wheelchair van for the regular outings for rest home and hospital residents. Newsletters are sent out to families informing them of upcoming events and are invited to attend.</p> <p>The RT is involved in the multidisciplinary review, which includes the review of the activity plan.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>There is evidence of resident and family involvement in the review of resident-centred care plans. The registered nurses evaluated all initial care plans within three weeks of admission. Written evaluations were completed six monthly or earlier for resident health changes in all files reviewed. There is evidence of multidisciplinary (MDT) team involvement in the reviews including input from the GP and any allied health professionals involved in the resident's care. Families are invited to attend the MDT review and they are asked for input if they are unable to attend. Short-term care plans (sighted) have been evaluated by the RN. The GP completes three monthly reviews.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The service provided examples of where a resident's condition had changed and the resident was reassessed for a higher level of care.</p>

<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Safety datasheets were readily accessible for staff. Chemicals were stored safely throughout the facility. Personal protective clothing was available for staff and seen to be worn by staff when carrying out their duties on the day of audit. Relevant staff have completed chemical safety training.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building has a current code of compliance that has been extended to 16 November 2016. A fulltime property manager oversees the property and gardening team and is available on call for facility matters. The property manager is the health and safety representative for the facility. Planned and reactive maintenance systems are in place and maintenance requests are generated through the Sway (Summerset way) on-line system (property services requests). All electrical equipment is under one year in use and is scheduled for electrical test and tag October 2016. Clinical equipment was purchased less than a year ago and is scheduled for calibration and/or functional testing in October 2016. Hot water temperatures have been tested and recorded monthly with evidence of corrective actions for temperatures outside of the acceptable range. Preferred contractors for essential services are available 24/7.</p> <p>The care centre is located on the first floor. Serviced apartments are on the ground floor. Corridors are wide in all areas to allow residents to pass each other safely. There is safe access to all communal areas and outdoor areas. There is an outdoor balcony on the care centre floor with seating and shade and lift access to the ground floor and external gardens and grounds. The external areas are well maintained.</p> <p>The care assistants and registered nurses (interviewed) state they have all the equipment required to safely provide the care documented in the care plans including electric beds, ultra-low beds, hoists and pressure injury relieving equipment.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are</p>	<p>FA</p>	<p>Visual inspection evidences toilet and shower facilities are of an appropriate design to meet the needs of the residents. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. All bedrooms have a hand basin. There are 22 rooms with ensembles and 6 rooms that share communal toilet/shower facilities. Communal toilet/shower facilities have a system that indicates if it is engaged or vacant. There are adequate numbers of communal toilets located near the communal</p>

assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.		areas.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	There are 27 single rooms and one double room. There is adequate room to safely manoeuvre mobility aids and transferring equipment such as hoists in the resident bedrooms. The doors are wide enough for ambulance trolley access. Residents and families are encouraged to personalise their rooms as viewed on the day of audit.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	Communal areas within the facility include a large main lounge that can accommodate rest home and hospital level residents and where most activities take place. There is a family room with tea making facilities. The dining room is open and spacious. There are seating alcoves within the facility. The communal areas are easily accessible for residents.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. All linen and personal clothing is laundered on-site. There are designated cleaning/laundry staff on duty each day. A chute is used to deliver dirty laundry from the care centre laundry room to the downstairs laundry. The laundry is well equipped and all machinery has been serviced regularly. There is a sluice area in the laundry with personal protective equipment available. The laundry has defined clean/dirty areas and an entry and exit door.  Cleaning trolleys sighted were well equipped and are kept in designated locked cupboards when not in use. There are locked chemical boxes securely fixed to the top of the cleaning trolleys. The chemical provider monitors the effectiveness of laundry and cleaning processes.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an	FA	There are emergency and civil defence plans to guide staff in managing emergencies and disasters. Emergencies and first aid are included in the mandatory in-service programme. There is a first aid trained staff member on every shift. Summerset Mountain View has an approved fire evacuation plan and fire drills have occurred six monthly. Smoke alarms, sprinkler system and exit signs are in place.

<p>appropriate and timely response during emergency and security situations.</p>		<p>The service has alternative cooking facilities (two BBQs) available in the event of a power failure. There are three civil defence cupboards in the facility and adequate stored water and food. Call bells were evident in residents' rooms, lounge areas and toilets/bathrooms. The facility is secured at night.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>Visual inspection evidences that the residents have adequate natural light in the bedrooms and communal rooms, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>The infection control programme is appropriate for the size and complexity of the service. There is an infection control responsibility policy that includes responsibilities for the infection control officer. The infection control officer (registered nurse) was originally a control officer at another Summerset site. The infection control programme is linked into the quality management system and reviewed annually at head office in consultation with infection control officers. There are three monthly infection control meetings scheduled, however these have not occurred (link 1.2.3.6). Infection control was a standing agenda item at the first quality meeting August 2016.</p> <p>Visitors are asked not to visit if they are unwell. Influenza vaccines are offered to residents and staff. Hand sanitisers are available throughout the facility.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The infection control officer attends an annual Summerset training day for infection control officers. The infection control officer also attends external training as available through the DHB.</p> <p>The infection control committee meetings include representatives from clinical areas, food services, management and property. The infection control committee is scheduled to meet quarterly (link 1.2.3.6) and infection events are forwarded to head office for benchmarking. The recent QI meeting August 2016 included infection control as an agenda item.</p> <p>The facility has access to an infection control nurse specialist at the DHB, external infection control consultant, public health, laboratory, chemical provider, GPs and expertise within the organisation at head office.</p>

<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>There are comprehensive infection control policies that are current and reflected the Infection Control Standard SNZ HB 8134:2008, legislation and good practice. These are across the Summerset organisation and were reviewed last in September 2014. The infection control policies link to other documentation and cross reference where appropriate.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The infection control officer is responsible for coordinating and providing education and training to staff. The induction package includes specific training around hand washing competencies and standard precautions. The service has been operational since December 2015 and all staff completed IC training as part of induction. Further IC training has yet to occur (link 1.2.7.5). Infection control is discussed at the recently implemented weekly caregiver meetings and covers current topics and areas of concern, trends and corrective actions. The 'infection control corner' in the staff office displays information and infection rates.</p> <p>Resident education occurs as part of providing daily cares. Care plans can include ways to assist staff in ensuring this occurs. There is an infection control noticeboard for resident/relative information.</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>The infection control policy includes a surveillance policy including a surveillance procedure, process for detection of infection, infections under surveillance, outbreaks and quality and risk management. Infection events are collected monthly and entered onto the SWAY electronic system. The infection control officer provides infection control data, trends and relevant information to staff and through the recently implemented quality meetings (link 1.2.3.6). Areas for improvement are identified, corrective actions developed and followed-up. The facility is benchmarked against other Summerset facilities of similar size. Surveillance results are used to identify infection control activities and education needs within the facility.</p> <p>There have been no outbreaks.</p>

<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>There are policies around restraints and enablers. The service currently has four hospital level of care residents assessed as requiring the use of restraint (bed rails). There are no residents with enablers. Restraint use is minimised and used as a last resort for resident safety. Ongoing consultation with the resident and family/whānau is also identified.</p> <p>Staff receive training around restraint minimisation that includes annual competency assessments.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>A restraint approval process and a job description for the restraint coordinator are in place. The restraint coordinator role is delegated to the nurse manager. All staff are required to attend restraint minimisation training annually, last in May 2016 attended by 15 care staff.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>PA Low</p>	<p>Only registered nursing staff can assess the need for restraint. Restraint assessments are based on information in the resident's care plan, discussions with the resident and family and observations by staff. Four of four hospital level residents' files where restraint was being used were selected for review. Each file included a restraint assessment and consent form that was signed by the resident's family. A restraint assessment tool meets the requirements of the standard, however not all assessments had been fully completed and restraint risks not linked to three of four resident centred care plans.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>A restraint register is in place. The register identifies the residents that are using a restraint, and the type(s) of restraint used. The restraint assessment identified that restraint is being used only as a last resort. Ongoing evaluation of the restraint use process includes reviewing the frequency of monitoring residents while on restraint. Monitoring forms are completed when the restraint is put on and when it is taken off.</p>
<p>Standard 2.2.4: Evaluation</p>	<p>FA</p>	<p>Individual restraint evaluations occur at care plan review. The review process includes discussing</p>

<p>Services evaluate all episodes of restraint.</p>		<p>whether continued use of restraint is indicated. Restraint use as a service is to be reviewed three monthly by the restraint committee during restraint meetings, however these are not always documented as completed (link 1.2.3.6).</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The restraint programme, including reviewing policies and procedures and staff education, is evaluated annually by the national quality manager and the national education manager.</p> <p>There have been no restraint meetings for the period from January to July. The first QI meeting was held in August 2016 and did include a restraint review (link 1.2.3.6). Restraint audit was completed in June 2016, at 91% compliance. There was a corrective action implemented which was completed on 22 June 2016.</p>

## 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>	PA Low	The Summerset group has a complaints register available for facilities to utilise that includes relevant information regarding the complaint. However, there is no evidence of a complaint register in place. Interviews with the village manager stated that there have been a few verbal complaints made that were not documented. There was no documented evidence that any complaints (verbal or written) have been made.	Summerset Mountain View did not have a complaints register in place. There was no evidence that any resident/family complaints made since the care centre opened in December 2015 were documented and entered into Sway (“The Summerset Way”).	<p>Ensure that there is a complaints register in place. Ensure that any resident/family complaints are documented and entered in to Sway.</p> <p>90 days</p>
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated</p>	PA Low	The Summerset group has a ‘clinical audit, meeting, training and compliance’ calendar. The calendar schedules the	(i) There have been no quality improvement meetings (including health and safety, infection control	(i) Ensure that meetings are held as per scheduled.

and the results communicated to service providers and, where appropriate, consumers.		meeting requirements for the month. Monthly quality improvement meetings are part of the annual calendar that includes discussion about clinical indicators (eg, incident trends, infection rates). There has only been one quality meeting held since opening December 2015. This service has not been following their meeting schedule.  The Summerset group has a data tool "Sway- the Summerset Way". Monthly and annual analysis of results is completed and provided across the organisation through Sway, which is integrated and accommodates the data entered. Discussion of quality data analysis was not evidenced in meetings.	and restraint) completed as per the annual calendar schedule for the period from January to July 2016. (ii) There has been no clinical/quality data and benchmarking analysis discussed at staff meetings for the period from January to July 2016.	(ii) Ensure that quality data and benchmarking analysis is discussed at staff meetings.  90 days
Criterion 1.2.3.7 A process to measure achievement against the quality and risk management plan is implemented.	PA Low	The annual calendar schedules the audit requirements for the month. Issues arising from internal audits are developed into corrective action plans, however audits reviewed did not evidence that corrective actions are followed up and completed.	The 2016 internal audit calendar schedule has not always been followed and corrective actions have not always been followed up and completed.	Ensure that the internal audit schedule is followed as per the annual calendar and that corrective actions are followed up and completed.  90 days
Criterion 1.2.3.9 Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of	PA Moderate	There is a documented health and safety, and risk management programme in place including practice. However, this is not being implemented. There is no identified hazard register	There has been no hazard register in place since the care centre opened in December 2015.	Ensure that there is a hazard register in place to capture any worksite

<p>choice, visitors, and those commonly associated with providing services. This shall include:</p> <p>(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;</p> <p>(b) A process that addresses/treats the risks associated with service provision is developed and implemented.</p>		<p>and hazards are not actively documented. Interviews with the H&amp;S representative identified he has completed external training and is new to the role.</p>		<p>accidents or near misses.</p> <p>30 days</p>
<p>Criterion 1.2.7.4</p> <p>New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p>	<p>PA Low</p>	<p>There is an annual education/training plan that is outlined on the 'clinical audit, training and compliance calendar'. Nine out of eighteen training sessions were completed for January to August 2016. Nine scheduled were not completed.</p>	<p>The 2016 education/training calendar schedule has not always been followed. Nine of eighteen training sessions have not been completed including (sexuality &amp; intimacy, privacy &amp; dignity, cultural awareness, dementia/challenging behaviour, documentation, wound care, pressure injury prevention, infection control and incontinence).</p>	<p>Ensure that the education/training calendar schedule is followed.</p> <p>90 days</p>
<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>	<p>PA Low</p>	<p>There are medicine management policies and procedures that align with recognised standards and guidelines for safe medicine management practice in accordance with the Medicines Care Guide for Residential Aged Care 2011. All medications are stored correctly. The medication fridge is monitored weekly. Ten resident medication charts on the electronic medication system and two paper based medication charts</p>	<p>Oxygen therapy had not been prescribed on the medication chart.</p>	<p>Ensure oxygen therapy is prescribed on the medication chart.</p> <p>30 days</p>

		<p>were reviewed (four hospital and eight rest home). The charts had photograph identification and allergy status recorded. Staff recorded the time and date of 'as required' medications. All 12 medication charts reviewed identified that the GP had reviewed the medication chart three monthly. One resident on oxygen therapy did not have this charted on the medication chart. One hospital resident had been assessed by the community service as requiring continuous oxygen however, the oxygen therapy and dosage had not been prescribed.</p>		
<p>Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA Moderate</p>	<p>The resident centred care plans reflected the current health status for one of two hospital resident files reviewed and two of four rest home residents.</p>	<p>The resident-centred care plans/clinical risk plans did not document the resident's current needs for the following. (i) Two residents with a high risk of pressure injury (one hospital and one rest home respite care), (ii) two rest home residents (one respite care and one under ACC) identified at high risk of falls, (iii) change of supports/needs for one hospital resident following discharge from hospital. The same resident did not have a current pain management plan in place, (iv) the initial support plan for one resident under ACC did not identify the reason for admission or the mobility supports required. The same resident did not have a pain management plan in place for identified pain on</p>	<p>Ensure all care plans (initial, long term and clinical risk plans) reflect the resident current health status.</p> <p>60 days</p>

			admission and (v) there were no documented interventions for a medical condition for a rest home resident discharged from hospital on respite care.	
<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>	<p>PA Moderate</p>	<p>There are a number of monitoring forms and charts available for use including (but not limited to) pain monitoring, restraint, blood sugar levels, weight, wound evaluations, food and fluid intake and repositioning charts, blood pressure monitoring and other vital signs.</p>	<p>(i) The respiration rate had not been taken on admission for one resident admitted under ACC following chest injury. The same resident did not have an investigation completed as instructed on the discharge summary. (ii) Registered nurse progress notes for one respite care resident documented the residents blood pressure was low and for monitoring. There had been no blood pressure recordings completed since the date of report.</p>	<p>Ensure all relevant observations, investigations and monitoring is completed as required or instructed.</p> <p>60 days</p>
<p>Criterion 2.2.2.1</p> <p>In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:</p> <p>(a) Any risks related to the use of restraint;</p> <p>(b) Any underlying causes for the relevant behaviour or condition if known;</p> <p>(c) Existing advance directives the consumer may have made;</p> <p>(d) Whether the consumer has been</p>	<p>PA Low</p>	<p>Two of four restraint assessments had been fully completed to include risks associated with the use of the restraint. One of four resident centred care plans fully documented the interventions to manage the risks of the restraint use.</p>	<p>1) Two of four restraint assessments reviewed did not identify the risks associated with the restraint use. 2) Three of four residents on restraint did not have interventions to manage the risks documented in the care plans.</p>	<p>1) Ensure restraint assessments are completed, including risks of the restraint use. 2) Ensure interventions to manage the risks are documented in the resident centred care plan.</p>

restrained in the past and, if so, an evaluation of these episodes; (e) Any history of trauma or abuse, which may have involved the consumer being held against their will; (f) Maintaining culturally safe practice; (g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer); (h) Possible alternative intervention/strategies.				60 days
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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.

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End of the report.