

Summerset Care Limited - Summerset By The Park

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:

Legal entity:	Summerset Care Limited
Premises audited:	Summerset By The Park
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 26 January 2017 End date: 27 January 2017
Proposed changes to current services (if any):	Three rooms in the care facility were assessed for their suitability as double rooms.
Total beds occupied across all premises included in the audit on the first day of the audit:	55



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

General overview of the audit

Summerset by the Park provides rest home and hospital level care for up to 108 residents (53 dual-purpose unit and 55 serviced apartments assessed as suitable to provide rest home level care). During the audit there were 55 residents. Three rooms in the care facility were assessed for their suitability as double rooms, which increase bed numbers to 111.

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, interviews with residents, family, management, staff and a general practitioner.

The nurse manager is appropriately qualified and experienced and is supported by registered nursing staff. There are quality systems and processes established. Feedback from the residents and families was positive about the care and services provided. An induction and in-service training programme is in place to provide staff with appropriate knowledge and skills to deliver care.

This certification audit identified that improvements are required in relation to the complaints process, communicating quality results with staff, corrective action plans, health and safety monitoring, incident/accident investigations, nursing interventions, nursing assessments, medication management, and food management.

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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Staff strive to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Code of Health and Disability Consumers' Rights. Cultural needs of residents are met. Policies are implemented to support residents' rights, communication and complaints management. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Care plans accommodate the choices of residents and/or their family/whānau. A complaints register is maintained.

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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Services are planned, coordinated, and are appropriate to the needs of the residents. A nurse manager is responsible for the day-to-day operations of the care facility. Quality and risk management processes are documented but not fully implemented. Strategic plans and quality goals are documented for the service. Adverse, unplanned and untoward events are documented by staff. The health and safety programme meets current legislative requirements. Human resources are managed in accordance with good

employment practice. An orientation programme is in place for new staff. A staff education and training programme is embedded into practice. Registered nursing cover is provided twenty-four hours a day, seven days a week. There are adequate numbers of staff on duty to ensure residents are safe. The residents' files are appropriate to the service type.

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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There is a comprehensive admission package available prior to or on entry to the service. The registered nurses are responsible for each stage of service provision. The registered nurses assess, plan and review residents' needs, outcomes and goals with the resident and/or family/whānau input. The InterRAI, risk assessments tools and monitoring forms are utilised. Care plans viewed in resident records demonstrated service integration and were evaluated at least six monthly. Resident files included medical notes by the general practitioner and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. The registered nurses, enrolled nurse and team leader/senior caregiver are responsible for administration of medicines and complete annual education and medication competencies. Medication charts have photo identification and allergy status noted. The medicine charts were reviewed at least three monthly by the general practitioner.

The diversional therapist provides and implements an interesting and varied activity programme. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical, cultural and cognitive abilities and preferences for each resident group.

Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on site. The food service is contracted to an external provider. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met. The menu has been reviewed by a dietitian.

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 holds a current warrant of fitness. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. Resident bedrooms are personalised. All bedrooms have ensembles. Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. Documented systems are in place for essential, emergency and security services. There is a staff member on duty at all times with a current first aid certificate.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Restraint minimisation and safe practice policies and procedures are in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit there were three residents using restraint and no residents with an enabler. Restraint management processes are adhered to.

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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Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. The infection control coordinator has received external training. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

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	43	0	2	5	0	0
Criteria	0	92	0	5	4	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 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The Health and Disability Commissioner's (HDC) Code of Health and Disability Consumers' Rights (the Code) brochures are accessible to residents and their families. Policy relating to the Code is implemented and care staff interviewed (two caregivers, three registered nurses (RNs), one activities coordinator) could describe how the Code is incorporated into their everyday delivery of care. Staff receive training about the Code during their induction to the service, which continues annually through the staff education and training programme.
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 are discussed with residents and families on admission. All resident's files reviewed contained written general consents including outings, transport, purchases and charges, and indemnity forms which were included in the admission process. Consent forms are signed for specific procedures. Caregivers interviewed confirmed consent is obtained when delivering cares. Advance directives identified the resident resuscitation status. They were signed by the resident (if able) and the general practitioner. The service acknowledges the resident is for resuscitation in the absence of a signed directive by the resident. Copies of enduring power of attorney (EPOA) were seen in the resident files as appropriate. Discussions with family members identified that the service actively involves them in decisions that affect their relative's lives. Eight signed admission agreements were sighted for eight long-term residents.

<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>	<p>FA</p>	<p>Information on advocacy services through HDC is included in the resident information pack that is provided to new residents and their family on admission. Advocacy brochures are also available at reception. Interviews with residents and family confirmed their understanding of the availability of advocacy services.</p> <p>The complaints process is linked to advocacy services. Two complaints reviewed indicated that HDC advocacy services were involved in supporting the complainant (link 1.1.13.1).</p> <p>Staff receive regular education and training on the role of advocacy services, which begins during their induction to the service. Aged Concern provides staff training around advocacy.</p>
<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>	<p>FA</p>	<p>The service has an open visiting policy. Residents may have visitors of their choice at any time. The service encourages the residents to maintain their relationships with their friends and community groups. Assistance is provided by the care staff to ensure that the residents participate in as much as they can safely and desire to do, evidenced through interviews and observations.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>PA Low</p>	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms for lodging informal complaints (feedback) and formal complaints are readily available. A suggestions box is held at reception.</p> <p>Information about the complaints process is provided on admission. Interviews with residents and family members confirmed their understanding of the complaints process. Staff interviewed were also able to describe the process around reporting complaints.</p> <p>An electronic complaints register is maintained. Eleven complaints were reviewed, ten were documented as closed but documentation indicated that only two were resolved. Evidence was sighted to confirm that each complaint had been managed in a timely manner including acknowledgement, and an investigation. One complaint lodged with HDC remains open pending further investigation by HDC. There is also one coroner's inquest that is open. Information requested by the coroner has been forwarded and the facility is awaiting a reply.</p> <p>Complaints received are not regularly communicated to staff (link 1.2.3.6). Corrective actions relating to the complaints received failed to indicate evidence of implementation (link 1.2.3.8).</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Details relating to the Code and the Health and Disability Advocacy Service are included in the resident information folder that is provided to new residents and their families. An RN discusses aspects of the Code with residents and their family on admission. Discussions relating to the Code are also held during the monthly resident/family meetings. All ten residents (five rest home, which included one in a care apartment; and five hospital) and four families (one rest home and three hospital) interviewed, reported that the residents' rights were being upheld by the service.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>The residents' personal belongings are used to decorate their rooms. All rooms have full ensuites. Privacy signage was on communal toilet and shower doors.</p> <p>The caregivers interviewed reported that they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas. They reported that they promote the residents' independence by encouraging them to be as active as possible. All of the residents and families interviewed confirmed that residents' privacy is respected.</p> <p>Guidelines on abuse and neglect are documented in policy. Staff receive annual education and training on abuse and neglect, which begins during their induction to the service.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. The care staff interviewed reported that they value and encourage active participation and input from the family/whānau in the day-to-day care of the resident. There were no residents living at the facility who identified as Māori.</p> <p>Māori consultation is available through links with Māori organisations within the community with one resident/kaumātua living in the retirement village who identifies with Ngati Pikiao. Staff receive annual education on cultural awareness that begins during their induction to the service.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services</p>	<p>FA</p>	<p>The service identifies the residents' personal needs and desires from the time of admission. This is achieved in collaboration with the resident, family and/or their representative. The staff demonstrated through interviews and observations that they are committed to ensuring each resident remains a person, even in a state of decline. Beliefs and values are discussed and incorporated into the care plan, evidenced in all eight care plans reviewed (three rest home and five hospital). Residents and families interviewed confirmed they were involved in developing the resident's plan of care, which included the identification of individual values</p>

which recognise and respect their ethnic, cultural, spiritual values, and beliefs.		and beliefs.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Professional boundaries are also defined in job descriptions. Interviews with all care staff confirmed their understanding of professional boundaries including the boundaries of the caregivers' role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings, and performance management if there is infringement with the person concerned.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	Registered nursing staff are rostered 24-hours a day, seven days a week. A general practitioner (GP) visits the facility twice weekly. Residents are reviewed by a general practitioner (GP) every three months at a minimum. Regular education and training programmes for staff are provided. A range of competency assessments are completed by staff in addition to in-service training. Reminders are provided to remind staff when competency assessments are due. The caregivers interviewed reported that the education and training sessions are very informative and helpful. Resident/family meetings are held monthly, led by the activities coordinator. Residents and families interviewed reported that they are satisfied with the services received. A satisfaction survey of the care facility also indicated that residents and family are satisfied. The service receives support from the district health board (DHB) which includes (but is not limited to) specialist visits. Physiotherapy services are offered three days a week. A van is available for regular outings. The GP interviewed is satisfied with the care that is being provided by the service.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive	FA	An open disclosure policy describes ways that information is provided to residents and families. The admission pack includes a comprehensive range of information regarding the scope of services provided to the resident on entry to the service, and any items they have to pay for that is not covered by the agreement. Evidence of contact being maintained with families including when an incident or care/health issue arises was documented on the twenty hard copy accident/incident forms that were randomly selected for review. Interviews with families confirmed that they are kept informed. A formal agreement is in place with an external provider for interpreter and translation services. The

to effective communication.		information pack is available in large print and can be read to residents. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so.
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Summerset by the Park is certified to provide rest home and hospital (geriatric and medical) level care in their care facility for up to 53 residents. In addition, there are 55 apartments certified for rest home level of care (across level two and level three). On the day of the audit there were 40 residents in the care facility (12 rest home and 38 hospital). There were five residents (four rest home and one hospital) in the apartments (link 1.2.4.2). All 53 rooms in the care facility floor level three are certified for dual-purpose. Summerset by the Park holds medical certification for their hospital residents.</p> <p>A relief village manager with appropriate and applicable experience is responsible for the retirement village until the village manager vacancy is filled. A nurse manager is appointed who is responsible for the rest home and hospital level residents. He is a registered nurse (RN) who has worked in managerial roles in aged care since 1994. He was appointed to his role in October 2016 and is supported by a clinical nurse lead/RN.</p> <p>The organisation is guided by a philosophy, vision and values. A 2017 operations business plan lists measureable goals and objectives. Business goals are regularly reviewed throughout the year.</p> <p>The nurse manager has attended a minimum of eight hours of professional development activities related to managing an aged care facility.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>The village manager is responsible for the administrative functions of the facility and the clinical nurse lead is responsible clinically during the absence of the nurse manager.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an</p>	PA Moderate	<p>The quality and risk management programme is established through the Summerset head office. Quality management is overseen by the organisation's regional quality manager. Policies and procedures reflect evidence of regular reviews as per the document control schedule. New and/or revised policies are made</p>

<p>established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>available for staff to read and sign that they have read and understand the changes. The village manager and nurse manager are held accountable for their implementation.</p> <p>The monthly collating of quality and risk data includes (but is not limited to) residents' falls, infection rates, skin tears and pressure areas. Data is collated and benchmarked against other Summerset facilities to identify trends. A resident satisfaction survey has recently been completed. An annual internal audit schedule is being implemented with audits completed as per the schedule. In addition to monthly internal audits, the regional quality manager completed six-monthly facility audits. Missing was evidence in the various staff meeting minutes to confirm that quality data and results were being communicated to staff.</p> <p>Corrective actions are developed where opportunities for improvements were identified following internal audits, and the recent resident satisfaction survey. Missing was evidence of the implementation of corrective actions initiated through the complaints process.</p> <p>Falls prevention strategies are being implemented. This includes the implementation of interventions on a case-by-case basis to minimise future falls. Sensor mats and physiotherapy services are utilised.</p> <p>The health and safety programme is overseen by a health and safety officer, and is supported by a health and safety team. A contractor induction programme is in place. Hazard identification forms and a hazard register are being implemented but the review of hazard controls are not documented as per Summerset health and safety policy. Links are in place to ensure the board is kept informed of any high risk events.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>PA Moderate</p>	<p>The service collects a comprehensive set of data relating to adverse, unplanned and untoward events, which is linked to the quality and risk management system (link 1.2.3.6). Immediate actions taken are documented on accident/incident forms. The forms are reviewed and investigated by the nurse manager. These reviews are behind schedule. Where risks are identified, they are processed as hazards.</p> <p>Discussions with the relief village manager and the clinical manager confirmed their awareness of statutory requirements in relation to essential notification. Public health authorities and the DHB were promptly notified following an outbreak in 2016 and a section 31 report was completed for a coroner's inquest. A dispensation request was sent to HealthCERT requesting a hospital level resident to temporarily remain in a rest home level apartment. This was approved by HealthCERT on 7 February 2017 for a period of three months.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are</p>	<p>FA</p>	<p>Job descriptions are in place for all relevant positions that describe staff roles, responsibilities and accountabilities. The practising certificates of nurses and visiting health professionals were current. Nine staff files were reviewed (three caregivers, three RNs, one clinical manager/RN, one diversional therapist, one housekeeper). Evidence of signed employment contracts, job descriptions, orientation, and staff training were</p>

<p>conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>sighted.</p> <p>Annual performance appraisals for staff were up-to-date. Newly appointed staff complete an orientation that is specific to their job duties. Interviews with two caregivers who cover the am and pm shifts confirmed that the orientation programme included a period of supervision over three days.</p> <p>The service has a training policy and schedule for in-service education. The in-service schedule is implemented and attendance is recorded. A system for determining staff competency is implemented. Competencies for RNs includes (but is not limited to) medication, syringe driver and insulin administration.</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>	<p>FA</p>	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. The nurse manager/RN and clinical nurse leader/RN work five days a week (Monday – Friday).</p> <p>The care facility (dual-purpose rest home/hospital) and 13 serviced apartments (rest home level) are located on the third level. There are 40 residents in the care facility (12 rest home and 38 hospital) and three in the apartments (two rest home and one hospital). This floor is staffed with two RNs in the am, two RNs or one RN and one EN in the pm and one RN during the night shift. There are adequate numbers of caregivers rostered 24/7 in the care facility.</p> <p>The care apartments (two rest home and one hospital) on the third level and on the second level (two rest home) are staffed with one caregiver on each shift. The hospital level resident in a rest home level apartment on the third floor is awaiting transfer to a room closer to the nurses’ station although the resident and family were reported as resistant to this change. They were assessed by NASC as hospital level in November 2016 (link 1.2.4). The resident is able to use their call bell. Meetings with the resident and family are underway.</p> <p>Separate staff complete laundry and cleaning duties. Staff reported that staffing levels and the skill mix was safe. Interviews with residents and families confirmed that they felt there was sufficient staffing. The roster is able to be changed in response to resident acuity.</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>	<p>FA</p>	<p>The residents’ files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24-hours of entry into each resident’s individual record. An initial support plan is also developed in this time. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents’ files are protected from unauthorised access by being held in a secure room. Archived records are secure in separate locked areas.</p> <p>Residents’ files demonstrate service integration. Entries are legible, dated, timed and signed by the relevant caregiver or nurse, including designation.</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>Residents' entry into the service is facilitated in a competent, equitable, timely and respectful manner. Admission information packs on the services for rest home and hospital level care are provided for families and residents prior to admission or on entry to the service. All admission agreements reviewed (all long-term residents as there were no short-term admissions), align with all contractual requirements. Exclusions from the service are included in the admission agreement.</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>Planned exits, discharges or transfers were coordinated in collaboration with the resident and family to ensure continuity of care. There were documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The residents and their families were involved for all exit or discharges to and from the service.</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 Moderate	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. An electronic medicine management system is implemented to ensure residents receive medicines in a safe and timely manner. Clinical staff who administer medications (RNs and senior caregivers) have been assessed for competency on an annual basis and attend annual medication education. Staff sign for the administration of medications on medication sheets held with the medicines and this was documented and up-to-date in all 16 medication signing sheets reviewed. The medication folders include a list of specimen signatures. Medication received (robotic rolls) are checked on delivery against the medication chart by the RN. All medications (including apartment residents) are stored safely in the treatment room care floor and administered from medication trolleys. The system in place for the management of controlled drugs meets the required regulations and guidelines. The controlled drugs register was correct and a weekly stocktake is conducted by an RN. The medication fridge is maintained within the acceptable temperature range. All eye drops and ointments were dated on opening. There was one resident self-medicating on the day of audit. A self-medication competency had been reviewed three monthly.</p> <p>Sixteen (two rest home in serviced apartments, four rest home and ten hospital level residents) medication charts were reviewed. All medication charts sampled had photo identification and allergy status. Staff were witnessed administering medications. Not all medication charts demonstrated the correct charting of 'as required' medications.</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>	PA Low	<p>All meals at the service are prepared and cooked on site by external contractors. There is a four weekly winter and summer menu which has been reviewed by a dietitian. Meals are prepared in a well-appointed kitchen and served to the residents in the adjoining dining room. Serviced apartment residents are able to receive meals in the main dining room. All kitchen staff are trained in safe food handling and receive ongoing training.</p> <p>The service records all fridge and freezer temperatures. Not all stored food was dated. Staff were observed serving and assisting residents with their lunchtime meals and drinks. Diets are modified as required. On admission, the registered nurse completes a dietary profile and a copy is given to the kitchen. The RN updates the profiles annually or more often if required and communicates the profile updates, likes and dislikes to food services staff. Supplements are provided to residents with identified weight loss issues. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed indicated satisfaction with the food 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>	FA	<p>There is an admission information policy. The reasons for declining entry would be if the service is unable to provide the level of care required or there are no beds available. Management would communicate directly with the referring agencies and family/whānau as appropriate if entry was declined.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>All residents are admitted with a care needs level assessment completed by the needs assessment and service coordination team prior to admission. Personal needs information is gathered during admission which formed the basis of resident goals and objectives. Assessments are reviewed at least six monthly. Appropriate risk assessments had been completed for individual resident issues with one exception (link 1.3.6.1). Registered nurses (RNs) have completed InterRAI training and the assessment tool was evident in resident files. Assessments for pain had been documented for resident files sampled (link 1.3.6.1).</p>
<p>Standard 1.3.5: Planning Consumers' service delivery</p>	PA Moderate	<p>The care plans in resident files sampled did not all fully describe the resident goals, supports and interventions required to meet desired goals as identified through assessments. The long-term care plan,</p>

<p>plans are consumer focused, integrated, and promote continuity of service delivery.</p>		<p>completed within three weeks, records the resident's problem/need and objectives; however, not all had sufficient interventions that reflected the residents' needs. Care plans were evaluated for identified issues and were completed six monthly, or as condition changed. Residents and families interviewed confirmed their involvement in the care planning process and multi-disciplinary meetings. Short-term care plans are in use for short-term needs and changes in health status. There was evidence of allied healthcare professionals involved in the care of the resident.</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>Care plans sampled were current but interventions did not always reflect the assessments conducted and the identified requirements of the residents (link 1.3.5.2). Interviews with staff (registered nurse and caregivers) and relatives confirmed involvement of families in the care planning process. Dressing supplies are available and a treatment room is stocked for use. 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.</p> <p>Wound assessment and wound management plans were in place for eight residents (four of whom had more than one wound and two of which were pressure injuries) and evidenced that all required documents were fully completed for these identified wounds. One further pressure injury had not been appropriately documented or managed.</p> <p>Monitoring occurs for weight, vital signs, blood glucose and challenging behaviour.</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 diversional therapist plans for the provision of the activities programme over seven days each week. The diversional therapist and the recreational therapist both work 40 hours a week and cover seven days. The programme is planned monthly and residents receive a personal copy of planned monthly activities. Activities planned for the day were displayed on noticeboards around the facility. A diversional therapy plan has been developed for each individual resident based on assessed needs. Residents are encouraged to join in activities that were appropriate and meaningful and are encouraged to participate in community activities. Links to the community are established with regular visits from a local school and participation in a reading programme. The service has a van that is used for resident outings. Residents were observed being encouraged and participating in activities on the days of audit. Family meetings and the next of kin survey provide a forum for feedback relating to activities as well as resident verbal feedback. Family members interviewed discussed enjoyment in the programme and the diversity offered to all residents.</p>
<p>Standard 1.3.8: Evaluation</p>	<p>FA</p>	<p>All initial care plans for long-term residents were evaluated by the RN within three weeks of admission and long term-care plans developed. Long-term care plans have been evaluated by the RN six monthly or earlier</p>

<p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>		<p>for any health changes for four of the eight files reviewed. Four residents had not been at the service six months. Written evaluations reviewed identified if the resident goals had been met or unmet. Family had been invited to attend multi-disciplinary meetings to discuss the care plan review and informed of any changes if unable to attend.</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 resident files sampled. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files as identified in the file of a resident who had been reassessed from rest home level care to hospital level care. Referrals to physiotherapy and dietitians were evidenced in files reviewed.</p> <p>There are documented policies and procedures in relation to exit, transfer or transition of residents. The residents and the families are kept informed of the referrals made by the service.</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>All chemicals were securely stored in locked areas throughout the facility. Chemicals are clearly labelled and safety material datasheets are available and accessible in all service areas. The hazard register is current. Staff interviewed confirmed they can access personal protective clothing and equipment at any time. As observed during the audit staff were wearing gloves, aprons and hats when required.</p> <p>The chemical supply company visits each month to check that supplies are adequate and that staff are managing chemicals safely and efficiently.</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 building warrant of fitness that expires in April 2017. The service employs a full-time maintenance manager responsible for overall maintenance of the building and a maintenance gardener who is responsible for the exterior and gardens. The maintenance manager is supported by two full-time and one part-time assistant. The facility uses an electronic database to ensure all maintenance systems, including hot water checks are scheduled and reviewed. Daily maintenance requests are addressed and undertaken by both internal maintenance and external contractors. There is an annual maintenance plan which is implemented. Electrical testing and tagging of electrical equipment is completed as required. Clinical</p>

		<p>equipment has been calibrated. The maintenance team is available on-call over 24-hours.</p> <p>The facility has wide corridors with sufficient space for residents to safely mobilise using mobility aids. There is safe access to the outdoor areas and courtyards on the ground floor. Seating and shade is provided.</p> <p>The caregivers and RNs stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans. Interviews with residents and family members confirmed the environment was suitable and safe to meet their needs.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>All dual-purpose resident rooms on the third floor have ensuites. The studio apartments on the second and third floor have ensuites. The hand basin, toilet and shower facilities are of an appropriate design to meet the needs of the residents. There are communal toilets with privacy locks located near the communal areas. Residents interviewed confirmed care staff respects the resident's privacy when attending to their personal cares.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All rooms are light and spacious. There is adequate room to safely manoeuvre using mobility aids or hoists. Residents and families are encouraged to personalise bedrooms. A tour of the facility evidenced personalised rooms, which included the residents own furnishing and adornments. Three rooms in the care facility were assessed to determine their suitability as double rooms. All three rooms were spacious in size and each room could comfortably accommodate two double beds. They will be used for married couples only.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided</p>	FA	<p>There is a large communal lounge and dining room on the third floor used for activities, recreation and dining activities. The dining room is spacious, and located directly off the kitchen. A well-equipped café is located adjacent to the kitchen and is open to residents and the public. A library is available adjacent to the entrance foyer. All areas are easily accessible for residents. There is a communal lounge in the second floor serviced apartment area being approved for rest home level care and all apartments have a lounge. The furnishings</p>

<p>with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>		<p>and seating are appropriate. Residents were seen to be moving freely both with and without assistance throughout the audit.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>There are policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. There are dedicated laundry staff and cleaners on duty seven days a week. The laundry is located on the ground floor and laundry is transported in covered trolleys by lift to the laundry. The laundry has an entry and exit door. There is appropriate personal protective wear readily available. The cleaner's trolley is stored in a locked area when not in use. Internal audits and the chemical provider monitor the effectiveness of the cleaning and laundry processes. Residents and relatives reported satisfaction with the laundry services.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Emergency and disaster policies and procedures, a pandemic plan and a civil defence plan are documented for the service. The education and training programme includes fire and security training, which begins during new staff orientation. Staff interviewed confirmed their understanding of emergency procedures. Required fire equipment was sighted on the day of audit. Fire equipment has been checked within required timeframes. There are adequate supplies readily available in the event of a civil defence emergency including food, water and blankets. Two gas barbeques are available.</p> <p>A call-bell system is in place. Residents were observed in their rooms with their call-bell alarms in close proximity. There is a minimum of one staff available 24-hours a day, seven days a week with a current first aid/CPR certificate. Activities staff also hold current first aid/CPR certificates.</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>Residents are provided with adequate natural light and safe ventilation. Documentation and visual inspection evidences that the environment is maintained at a safe and comfortable temperature. The residents and family interviewed confirmed temperatures were comfortable. There is a designated external smoking area.</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>Summerset by the Park has an established infection control programme. The infection control nurse is a registered nurse who has been in the role for ten months. The infection control programme is appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator is supported by the clinical manager, nurse manager, quality manager and other Summerset infection control nurses. External support is available from Bug Control, the district health board, infection control specialists and geriatricians. Infection control audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The infection control programme has been reviewed monthly and annually and linked into the quality management system. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved.</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>There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse and IC team have good external support from the Summerset care head office, public health unit and the IC nurse specialist at the DHB. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</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</p>	<p>FA</p>	<p>Summerset by the Park uses the Summerset group infection control policies and procedures. The policies and procedures are appropriate for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff.</p>

type of service provided.		
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	The infection control nurse has completed external training and is currently working on an online infection control qualification. All staff receive orientation and ongoing infection control education. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.
<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>	FA	Infection surveillance is an integral part of the infection control programme and is described in the infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection and is benchmarked with similar facilities. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and compared month by month. Outcomes and actions are discussed at quality meetings (link 1.2.3.6) and daily staff briefings and results are posted for staff to view. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the site manager. There has been one outbreak which was well documented and managed. Public health authorities were notified in a timely manner. Monthly and annual reviews are comprehensively documented and reviewed at quality meetings.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service has documented systems in place to ensure the use of restraint is actively minimised. There were three hospital level residents with a restraint and no residents using an enabler.</p> <p>Staff interviews confirmed that guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques. Policies and procedures include definitions of restraint and enabler that are congruent with the definition in NZS 8134.0. Staff education including assessing staff competency on RMSP/enablers has been provided.</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</p>	FA	The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator (RN) and for staff are documented and understood. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements.

restraint, and ongoing education on restraint use and this process is made known to service providers and others.		
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	<p>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. The restraint assessment tool meets the requirements of the standard.</p> <p>Two hospital level residents' files where restraint was being used (bed rails and lap belt) were selected for review. Each file reviewed included a restraint assessment and consent form that was signed by the resident's family.</p>
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	<p>Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint.</p> <p>Restraint authorisation is in consultation/partnership with the resident, family and the GP. The use of restraint is linked to the resident's restraint care plan. An internal restraint audit monitors staff compliance in following restraint procedures.</p> <p>Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Consistent evidence to verify two hourly checks were sighted on the monitoring forms for the two residents using restraint.</p> <p>A restraint register is in place providing an auditable record of restraint use and is completed for residents requiring restraints.</p>
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations are conducted three-monthly, evidenced in one resident file where restraint had been in use for over three months.
Standard 2.2.5: Restraint Monitoring and Quality Review	FA	The restraint minimisation programme is discussed and reviewed at a national level and includes identifying trends in restraint use, reviewing restraint minimisation policies and procedures and reviewing the staff education and training programme.

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

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	<p>Eleven complaints received in 2016 were selected for review. The complaints process indicated that the acknowledgement and investigation for each complaint had been managed in a timely manner but failed to reflect evidence of resolution in eight of the complaints. The two complaints that were documented as resolved had involved HDC Advocacy services.</p>	<p>Eight of ten complaints that were documented as closed failed to reflect evidence of resolution.</p>	<p>Ensure the complaints process includes evidence of resolution (or justification as to why this isn't possible) before closing the complaint.</p> <p>90 days</p>
<p>Criterion 1.2.3.6</p>	PA Low	<p>Quality improvement data is being collected, analysed and evaluated. Data is benchmarked against other Summerset facilities with targets</p>	<p>There are gaps in meeting minutes</p>	<p>Ensure staff are kept</p>

Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.		established. The internal audit programme is being implemented. Missing is evidence of quality and risk data and results being communicated to staff.	around the reporting of quality and risk information.	informed of quality and risk management information including outcomes and areas identified for improvements. 90 days
Criterion 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.	PA Low	Evidence of corrective actions was sighted for the internal audit programme and the recent resident satisfaction survey. The documentation for complaints also included corrective actions but a system to ensure that the corrective actions had been implemented had not been established.	Evidence to support the implementation of corrective action plans was missing for three of eleven complaints received in 2016 where recommendations had been made.	Ensure there is evidence to support the implementation of corrective actions that originate from a complaints investigation. 90 days
Criterion 1.2.3.9 Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This	PA Low	The health and safety plan has been updated to incorporate legislative changes. A health and safety team has been established and the recently appointed health and safety officer is scheduled to attend external training. Health and safety is a regular agenda item in meeting minutes (link 1.2.3.6). Staff complete a hazard identification form when a hazard is identified. Hazards that cannot be eliminated are added to the hazard register. As per policy, all hazards controls will be monitored as per the schedule identified on the hazard register. Maintenance staff reported that hazards are regularly checked but that this is not being documented as per policy. A monthly hazard monitoring form was	There is a lack of evidence to indicate that hazards identified on the hazard register are regularly monitored.	Ensure hazards are regularly monitored as per the health and safety plan for the organisation.

<p>shall include: (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; (b) A process that addresses/treats the risks associated with service provision is developed and implemented.</p>		<p>sighted but is not consistently being completed.</p>		<p>90 days</p>
<p>Criterion 1.2.4.3 The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	<p>PA Moderate</p>	<p>Staff complete an accident incident form following an adverse event. Information is held both in hard copy and electronically. Neurology observations are completed if there is a suspected injury to the head. The nurse manager is responsible for reviewing all accident/incident forms. This process is behind schedule with a selection of accident/incident forms reviewed for November and December 2016 awaiting review by the nurse manager.</p>	<p>Twelve of twenty accident/incident forms selected for review (November and December 2016) had not been signed off by the clinical manager as closed. The clinical manager confirmed that there is a backlog and that this is an issue that he is currently working on.</p>	<p>Ensure adverse events are reviewed by the nurse manager in a timely manner. 30 days</p>
<p>Criterion 1.3.12.1 A medicines management</p>	<p>PA Moderate</p>	<p>The signing sheets for regular and 'as required' medications corresponded with the instructions on the medication chart. Regular</p>	<p>Seven of sixteen medication charts</p>	<p>Ensure 'as required'</p>

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.		medications were prescribed correctly. Ten of sixteen medication charts had been reviewed by the GP three monthly. Six residents were admitted within three months. There are no standing orders in use. There were records of a weekly stocktake of controlled drugs. Not all as required medications had indications for use.	did not identify indications for use for 'as required' medications.	medications have indications for use documented. 30 days
Criterion 1.3.13.1 Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.	PA Low	All meals at the service are prepared and cooked on site by external contractors. There is a four weekly winter and summer menu which has been reviewed by a dietitian. Meals are prepared in a well-appointed kitchen and served to the residents in the adjoining dining room. Serviced apartment residents are able to receive meals in the main dining room. All kitchen staff are trained in safe food handling and receive ongoing training. Food stored in the pantry, fridge and freezer did not always evidence decanting, expiry or preparations dates.	i) Foodstuffs in the fridge, freezer and pantry did not evidence dates of when they were initially opened. ii) Prepared foodstuffs in the fridge (eg, prepared meals) do not evidence initial preparation dates. iii) Dried goods such as herbs, spices, flour etc. did not always evidence expiry dates or decanting dates.	Ensure all foodstuffs are dated and stored as per policy. 90 days
Criterion 1.3.5.2 Service delivery plans describe the required support and/or	PA Moderate	Care plans were in place for all residents and documented care plan interventions for some risks identified through InterRAI assessment process. Care staff interviewed were able to explain the care and support needed for all residents in their care. Care plans did not all include required interventions to support mobility, pressure injury	Three hospital residents did not have sufficient interventions documented in	Ensure that resident care plans include nursing interventions

<p>intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>		<p>prevention and management, oxygen therapy, dietary requirements, pain and communication. One hospital resident (tracer) non English speaking, did not have methods of communication documented, although staff confirmed they could contact family when required. Two hospital residents identified as high risk of pressure injury with current pressure injuries did not have sufficient interventions in place to minimise further risk. Staff confirmed that interventions are in place and turning charts were completed however there were insufficient interventions documented to direct all aspects of related care. Two hospital residents had assessments identifying pain however care planning did not reflect sufficient appropriate interventions for pain management. Two hospital residents identified with dietary requirements. One had insufficient interventions documented and the other had contradictory interventions. Care staff were observed encouraging and assisting residents with food and fluids. Snacks are available between meals and protein drinks were used. One hospital resident had regular oxygen charted on the medication chart, however this and oxygen concentrator use were not documented in the care plan. This was administered as charted.</p>	<p>the care plan to address all identified needs.</p>	<p>for identified needs. 30 days</p>
<p>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.</p>	<p>PA Moderate</p>	<p>A recent hospital admission had admission documentation, assessments and initial and long-term care plans well-documented however an unstageable pressure injury identified on admission had not been correctly staged and did not have a wound assessment and management plan documented and the wound was not entered on the wound register or appropriately managed. An incident form had been completed and progress notes document treatment and updated status. The registered nurse reported that the wound was now almost healed. The resident had a second pressure injury. The wound was managed and documented appropriately. A pain assessment was documented on admission, but had not been reviewed following the development of the pressure injury. Prevention of further risks for this resident was managed by regular position changes, an alternating air mattress, dietary interventions and regular skin care.</p>	<p>i) One unstageable pressure injury as identified in photos had not been staged and was not entered on the wound register and there was no evidence of a wound assessment, treatment plan or review documentation. The only intervention was</p>	<p>i) Ensure that wound assessments, plans and reviews are completed for all wounds and that appropriate wound care is implemented. ii) Ensure that pain assessments and monitoring are implemented</p>

			<p>the application of moisturiser.</p> <p>ii) Pain assessment and monitoring had not been reviewed following the development of a stage two sacral pressure injury.</p>	<p>as required.</p> <p>30 days</p>
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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, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.