

# Summerset Care Limited - Summerset at Wigram

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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 at Wigram
<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: 7 June 2017    End date: 8 June 2017
<b>Proposed changes to current services (if any):</b>	

**Total beds occupied across all premises included in the audit on the first day of the audit: 47**



# 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 at Wigram provides rest home and hospital (medical and geriatric) level care for up to 53 residents in the care centre and up to 20 residents at rest home level care across the care apartments. On the day of the audit there were forty-seven residents including three rest home residents in serviced apartments. The care centre opened in September 2016. The service is managed by a village manager and a care centre manager. 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 care centre manager (registered nurse) who oversees the care centre. There are quality systems and processes being implemented. An induction and in-service training programme is in place to provide staff with appropriate knowledge and skills to deliver care.

This certification identified areas for improvement around care plans, medication monitoring, restraint assessment documentation and restraint monitoring documentation.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The facility 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. Complaints processes are being implemented and complaints and concerns are managed and documented. Residents and family interviewed verified ongoing involvement with community.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Summerset at Wigram implements a quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to include monthly quality improvement meetings. Surveys and monthly resident meetings provide residents and families with an opportunity for feedback about the service. Quality performance is reported to staff at meetings and includes discussion about incidents, infections and internal audit results. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care. There is a staffing policy 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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The service has assessment processes and residents' needs 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. Risk assessment tools and monitoring forms were available and implemented. Resident centred care plans were individualised. A diversional therapist plans and implements an integrated activity programme. The activities meet the individual recreational needs and preferences of the consumer groups. There are outings into the community and visiting entertainers.

The service uses an electronic medication management system. 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 catering company who cook and prepare all meals in the facility's well-equipped kitchen. There is also a café located on the ground floor which is open to residents and visitors. Resident's individual dietary needs are 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 certificate of public use. Resident bedrooms are spacious and personalised with access to ensuites. There is 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. Housekeeping staff maintain a clean and tidy environment. All laundry and linen is completed on-site. There is plenty of natural light in all rooms and the environment is 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. Staff receive regular education and training on restraint minimisation. There were four residents requiring the use of a restraint and no residents using an enabler at the time 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.

The infection control programme is appropriate for the size and complexity of the service. The infection control coordinator (registered nurse) is responsible for coordinating and providing education and training for staff. The infection control coordinator 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 includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Somerset facilities and with two other large aged care providers.

## 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	46	0	2	2	0	0
<b>Criteria</b>	0	97	0	2	2	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
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Discussions with staff (six caregivers including one who works in the care apartments, one enrolled nurse, two registered nurses (RN) including the clinical nurse leader and one diversional therapist) confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Nine residents (five rest home and four hospital level of care) and five relatives (four 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.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. Written general and specific consents were evident in the seven resident files (three rest home and four hospital level of care) reviewed. Caregivers and registered nurses interviewed confirmed consent is obtained when delivering cares. Resuscitation orders have been signed by the resident and the general practitioner (GP). The GP discusses resuscitation with families/EPOA where the resident was deemed incompetent to make a decision.</p> <p>Discussion with family members identified that the service actively involves them in decisions that affect their relative's lives. Seven admission agreements sighted were signed.</p>

<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	<p>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 provides 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>
<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	<p>Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. Activities programmes include 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. Relatives and friends are encouraged to be involved with the service and care.</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>	FA	<p>The organisational complaints policy states that the village manager has overall responsibility for ensuring all complaints (verbal or written) are fully documented and investigated. There is an electronic complaints register that includes relevant information regarding the complaint. The number of complaints received each month is reported monthly to staff via the various meetings. There have been three complaints received relating to the care centre since the service opened. The one resolved complaints documentation included follow-up letters, and resolutions were completed within the required timeframes. Two complaints were recent and remain open. 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>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>The service provides information to residents that include the Code, complaints and advocacy. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Residents and relatives interviewed identified they are well informed about the Code of Rights. Monthly resident meetings provide the opportunity to raise concerns. An annual residents/relatives survey is completed. Advocacy and Code of Rights information is included in the information pack and are available at reception.</p>
<p>Standard 1.1.3: Independence, Personal</p>	FA	<p>Staff interviewed could 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</p>

<p>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>employment. Contact details of spiritual/religious advisors are available. Resident files include cultural and spiritual values. Residents and relatives interviewed reported that residents can choose to engage in activities and access community resources. There is an elder abuse and neglect policy and staff education and training on abuse and neglect has been provided.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>Summerset at Wigram 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. At the time of audit there were no residents who identified as Māori. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with disability and other community representative groups as requested by the resident/family. Cultural needs are addressed in the care plan. Staff interviewed could describe how they can ensure they meet the cultural needs of 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>	<p>FA</p>	<p>An initial care planning meeting is carried out where the resident and/or whānau as appropriate/able are invited to be involved. Individual beliefs or values are further discussed and incorporated into the care plan. Six-monthly multidisciplinary team meetings occur to assess if needs are being met. Family are invited to attend. Discussion with relatives confirmed values and beliefs are considered. Residents interviewed confirmed that staff consider their culture and values.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Staff job descriptions include responsibilities and staff sign a copy on employment. The quality improvement meetings occur monthly and include discussions on professional boundaries and concerns as they arise. Management provide guidelines and mentoring for specific situations. Interviews with the village manager, care centre manager and registered nurses confirmed an awareness of professional boundaries.</p>

<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Residents and relatives interviewed spoke very positively about the care and support provided. Staff have a sound understanding of principles of aged care and state that they feel supported by the village manager, care centre manager and clinical nurse lead. 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 and procedures are sufficiently detailed to allow effective implementation by staff. There is a quality improvement programme that includes performance monitoring against clinical indicators and benchmarking against like services within the group as well as other external aged care providers. There is a culture of ongoing staff development with an in-service programme being implemented. There is evidence of education being supported outside of the training plan. Services are provided at Summerset at Wigram that adhere to the Health &amp; Disability Services Standards and all approved service standards are adhered to. There are implemented competencies for caregivers and registered nurses including but not limited to: insulin administration, medication, wound care and manual handling. RNs have access to external training.</p> <p>A strong teamwork approach, encouraged by positive leadership and regular team building events fosters a culture of good practice. Examples include the falls project (described in 1.2.3), infection control practices and low restraint use.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents and family members stated they were welcomed on entry and were given time and explanation about services and procedures. Family members interviewed also stated they are informed of changes in the health status of residents and incidents/accidents and incident forms sampled confirmed this. Resident/relative meetings are held monthly. The village manager and the care centre manager have an open-door policy. 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.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The service provides care for up to 72 residents at hospital (geriatric and medical) and rest home level care. There are 52 dual-purpose beds in the care centre on level one and 20 serviced apartments across the ground floor and second floor certified to provide rest home level care. On the day of the audit, there were 47 residents in total - 29 residents at rest home level (three in the serviced apartments) including two on respite care and 18 residents at hospital level including one on respite care and one on an end of life respite care contract. The remaining residents were under the aged related contract.</p> <p>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 at Wigram has a site-specific business plan and goals that is developed in consultation with the village manager, care centre manager and regional operations manager (ROM). The quality plan is reviewed regularly throughout the year. There is a full evaluation at the end of the year. The first quarter evaluation of the 2017 plan was sighted. The village manager has been with Summerset for four years and in the current role since October 2016. The village manager is supported by a care centre manager. The care centre manager has been in the position for 11 months. The care centre manager is a registered nurse who has experience working in aged care in leadership roles. The care centre manager is supported by the clinical nurse lead. Village managers and care centre managers attend annual organisational forums and regional forums over two days. The care centre manager attends clinical education. There is a regional quality manager who is available to support the facility and staff. The village manager has attended at least eight hours of leadership professional development relevant to the role.</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>During a temporary absence, the care centre manager will cover the village manager's role. The regional quality manager provides oversight and support. The audit confirmed the service has operational management strategies and a quality improvement programme to minimise risk of unwanted events.</p>
<p>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>	FA	<p>Summerset at Wigram is implementing the organisation's quality and risk management system. There are policies and procedures being implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed on a regular basis. The content of policy and procedures are detailed to allow effective implementation by staff.</p> <p>The Summerset group has a 'clinical audit, training and compliance' calendar. The calendar schedules the training and audit requirements for the month and the nurse manager completes a 'best practice' sheet confirming completion of requirements. The best practice sheet reports (but not limited to): meetings held, induction/orientation, audits, competencies and projects and is forwarded to head office as part of the ongoing monitoring programme.</p> <p>There is a meeting schedule including (but not limited to) monthly quality improvement, weekly caregiver and monthly registered staff meetings that include discussion about clinical indicators (e.g., incident trends,</p>

		<p>infection rates). Health and safety, infection control and restraint meetings occur monthly. There are other facility meetings held such as kitchen and activities. An annual residents/relatives survey (completed November 2016) reports overall 100% feedback of experience being good or very good.</p> <p>The service is implementing an internal audit programme that includes aspects of clinical care. Issues arising from internal audits are developed into corrective action plans. Monthly and annual analysis of results is completed and provided across the organisation. There are monthly accident/incident benchmarking reports completed by the nurse manager that break down the data collected across the rest home and hospital and staff incidents/accidents. Infection control is also included as part of benchmarking across the organisation. Health and safety internal audits are completed. Summersets clinical and quality manager analyses data collected via the monthly reports and corrective actions are required based on benchmarking outcomes. Summerset has a data tool "Sway - the Summerset Way". Sway is integrated and accommodates the data entered.</p> <p>There is a health and safety and risk management programme in place including policies to guide practice. The office manager is the health and safety representative (interviewed).</p> <p>The service addresses health and safety by recording hazards and near misses into SWAY, sharing of health and safety information and actively encourage staff input and feedback. Each month there is a health and safety focus topic and staff are provided with resources and education about the topic. The service ensures that all new staff and any contractors are inducted to the health and safety programme. The health and safety programme has been designed around the new legislation.</p> <p>Falls prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. All falls are recorded on an A2 size floor plan for each floor and analysis by the falls champion includes the time of day, the place, staff on duty in the area, the resident, and the place of the falls. When trends are identified these are addressed by care plan updates for individual residents (for example a resident having cares completed earlier in the morning) and education for staff.</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</p>	<p>FA</p>	<p>Incident and accident data has been collected and analysed. Discussions with the service confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Two stage 5 pressure injuries and an outbreak have been appropriately notified. Fifteen resident related incident reports for seven residents were reviewed. All reports and corresponding resident files reviewed evidence that appropriate clinical care has been provided following an incident. The incident reporting policy includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Data is linked to the organisation's benchmarking programme and used for comparative purposes.</p>

family/whānau of choice in an open manner.		
<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>	FA	<p>There are human resources policies to support recruitment practices. A list of practising certificates is maintained. Seven staff files (one care centre manager, one RN, one clinical nurse lead, one diversional therapist, and two caregivers) were reviewed and all had relevant documentation relating to employment. The service has not yet been open for a full year so annual performance appraisals have not yet been completed. 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. A full orientation was completed for staff prior to the opening of the service. Staff interviewed could describe the orientation process and believed new staff were adequately orientated to the service. There is an annual education plan that is outlined on the 'clinical audit, training and compliance calendar'. The plan is being implemented. A competency programme is in place with different requirements according to work type (e.g., caregivers, registered nurse and household staff). Core competencies are completed and a record of completion is maintained on staff files as well as being scanned into 'Sway'. Seven of the eight RNs are interRAI trained.</p> <p>Staff interviewed were aware of the requirement to complete competency training. Caregivers complete an aged care programme.</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 care centre manager work 40 hours per week Monday to Friday and are available on call for any emergency issues or clinical support. The clinical nurse lead works full time Wednesday to Saturday. In the care centre, there is an RN on duty 24/7 and an enrolled nurse on morning and afternoon shift. There are six caregivers on morning shifts (four full shifts and two short shifts) plus an extra caregiver from 6am to 8am and then 10am to 11am (to complete the morning tea round). There are five on the afternoon shifts (three full shifts and two short shifts) and two on night shifts. The RN on duty provides oversight to the rest home residents in the serviced apartments. One caregiver is on duty in the serviced apartments on a morning shift, an afternoon shift and a night shift to assist the three rest home residents. Staff carry pagers that alert them to call bells and walkie talkies so they can communicate effectively.</p> <p>A staffing levels and skills mix policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery. A staff availability list ensures that staff sickness and vacant shifts are covered. Caregivers interviewed confirmed that staff are replaced when off sick.</p> <p>Interviews with residents and relatives confirmed that staffing levels are sufficient to meet the needs of residents.</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 resident files sampled were appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Other residents or members of the public cannot view sensitive resident information. Resident files are protected from unauthorised access by being held in a locked office. Care plans and notes were legible and where necessary signed (and dated) by a registered nurse. Entries are legible, dated and signed by the relevant caregiver or registered nurse including designation. Individual resident files demonstrate service integration. There is an allied health section that contained general practitioner notes and the notes of allied health professionals and specialists involved in the care of the resident.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>All residents have a needs assessment completed prior to entry that identifies the level of care required. The care centre 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 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>	<p>FA</p>	<p>There is an exit, discharge and transfer policy that describes guidelines for death, discharge, transfer, documentation and follow-up. All relevant information is documented and communicated to the receiving health provider or service. The service uses the DHB "yellow envelope" initiative to improve communication on admission to and discharge from public hospital. 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>	<p>PA Moderate</p>	<p>The service medication management system follows recognised standards and guidelines for safe medicine management practice in accordance with the Medicines Care Guide for Residential Aged Care 2011. RNs and ENs are responsible for the administration of medications. Senior caregivers' complete competencies for the checking and witnessing of medications as required. Medication competencies and education has been completed annually. All medications delivered were evidenced to be checked by a registered nurse on delivery with any discrepancies fed back to the supplying pharmacy. The service has implemented an electronic medication system. There was one resident self-medicating on the day of audit. The resident had a current assessment of competency to self-administer medications, however the medication chart was not updated by the GP to reflect that staff administers some prescribed medications. Medication administration was not observed to be fully compliant with policy and procedure.</p>

		<p>Fourteen resident medication charts on the electronic medication system were reviewed (six rest home and eight hospital). The charts had photograph identification and allergy status recorded. The prescribing of regular and 'as required' medications meets legislative requirements. Staff recorded the time and date of 'as required' medications. The clinical nurse lead monitors for missed medications.</p> <p>All 14 medication charts reviewed identified that the GP had reviewed the medication chart three monthly.</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>Summerset has comprehensive nutritional management policies and procedures for the provision of food services for residents. The provision of meals at Summerset at Wigram is contracted-out to White-tie catering who provide all aspects of the food service. The contracted company is responsible for kitchen staff recruitment, food service, food handling, menu, dishwashing, sanitation, and personal hygiene.</p> <p>The facility has a large purpose-built kitchen on the ground floor adjacent to the café and dining area of the care apartments. The menu is designed and reviewed by a registered dietitian. Food is transported in bain-maries to the satellite kitchen in the main dining room of the care centre on level one. There is a lift near the service area that is used to transport food carriers to each floor and dishes back to the kitchen</p> <p>Resident likes/dislikes and preferences are known and accommodated with alternative meal options. Special diets include low residue, pureed meals as assessed and diabetic desserts. The cook receives a dietary profile for each resident. The fridge, freezer and dishwasher have daily temperatures 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.</p> <p>Residents and family members interviewed expressed that there was a variety of menu options available and that food was "beautifully presented and tasted great".</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</p>	<p>FA</p>	<p>The reason for declining service entry to potential residents, should this occur, is communicated to the potential resident or family/whānau and they are referred to the original referral agent for further information.</p>

appropriate.		
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	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. Risk assessment tools are used to identify the required needs and interventions required to meet resident goals. In files sampled the interRAI assessment was completed within 21 days for new admissions. All residents have an interRAI assessment in place.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Moderate	Resident centred care plans sampled described most of the individual support and interventions required to meet the resident's goals. The care plans sampled reflected the outcomes of risk assessment tools. Care plans demonstrate service integration and include input from allied health practitioners.  Short-term care plans were in use for changes in health status.  There is documented evidence of resident/family/whānau involvement in the care planning process. Residents/relatives interviewed confirmed they participate in the care planning process.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	When a resident's condition changes, the RN initiates a review and if required a GP or nurse specialist consultation. Relatives interviewed state their relatives' needs are met and they are kept informed of any health changes. There is documented evidence in the resident files of family notification of any changes to health including infections, accidents/incidents and medication changes. Residents interviewed stated their needs are being met.  Adequate dressing supplies were sighted. Initial wound assessments with ongoing wound evaluations and treatment plans were in place for twelve wounds including three skin tears, one surgical wound, two chronic venous leg ulcers, one superficial scratch, one blister, two unstageable pressure injuries, one stage 1 pressure injury and one stage 2 pressure injury. A Nurse Maude wound care nurse specialist had reviewed the pressure injuries and chronic venous leg ulcers. Wound management plans reflected the recommendations made by the wound care nurse specialist. All wounds were reviewed within the prescribed timeframes.  Care plans reviewed for residents with pressure injuries and chronic wounds addressed pain management, nutrition and hydration and equipment or interventions required to maintain patient comfort and relieve pressure to those skin areas which may be susceptible to breakdown or had broken down.  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

		<p>continence and wound advice is available as needed. A continence nurse specialist is available as required.</p>
<p><b>Standard 1.3.7: Planned Activities</b></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 qualified and registered diversional therapist (DT) 30 hours a week to coordinate and deliver the integrated rest home and hospital programme. The DT attends regional DT workshops and the monthly Somerset teleconferences between all DTs and activity persons. There is a senior caregiver who facilitates the programme when the DT is on annual leave. The programme is five days a week with caregivers being involved in weekend activities such as ensuring exercises and movies are initiated as scheduled.</p> <p>The programme is planned a month in advance and includes set 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, library visits, inter-home visits. There are also opportunities to attend competitions and community groups/events including concerts and theatre productions. Pet therapy involves a daily visiting dog and fortnightly SPCA visits. Residents are encouraged to maintain their former community links. Church services are held fortnightly for all denominations and Holy Communion is available weekly. One-on-one contact is made with residents who are unable or choose not to participate in group activities.</p> <p>The service has a wheelchair van for outings. The DT has a current first aid certificate.</p> <p>Resident/family meetings provide an opportunity for residents to feedback on the programme. Newsletters are sent out to families informing them of upcoming events and are invited to attend. Families interviewed confirmed they receive the regular newsletters.</p> <p>Activity assessments were sighted in all seven resident files and had been completed in consultation with the family on admission. The DT is involved in the MDT reviews as evidenced in documentation sighted in resident files. Activity plans and care plans were reviewed at the same time.</p>
<p><b>Standard 1.3.8: Evaluation</b></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. In files sampled initial care plans were evaluated by the registered nurses within three weeks of admission. In five of seven files reviewed (two residents have not been at the service six months) written evaluations were completed six monthly or earlier for resident health changes. Care plan evaluations reflect progress towards the desired goal or outcome. There is evidence of multidisciplinary (MDT) team involvement in the reviews including input from the GP and any allied health professionals involved in the residents' care. Families are invited to attend the MDT review and are sent a copy of the care plan 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>	FA	<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>	FA	<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. Chemical bottles sighted have correct manufacturer labels. Chemicals were stored safely throughout the facility. The property manager is the approved handler for chemicals. Personal protective clothing is available for staff and was seen to be worn by staff when carrying out their duties on the day of audit. Relevant staff have completed chemical safety training. Sluice rooms were observed to be locked on the days of audit.</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>	FA	<p>The care centre is a three-level facility. On the ground floor, there are service areas and serviced care apartments. There are also serviced apartments on level two. Twenty serviced apartments are certified to provide rest home level care. On level one, the care centre includes 49 rest home and hospital level rooms (all dual-purpose). Four of the rooms have been assessed as suitable for couples (double rooms). The service could have 53 residents on this floor.</p> <p>There is one lift and stairwells between floors. The lift is large enough for mobility equipment including a stretcher. On level one, there is a nurse's station, medication/treatment room, doctor's room and nurse manager's office. On the two serviced apartment floors there is a nurse's station area.</p> <p>The Certificate of Public Use was re-issued on 23 March 2017. There is a full-time property manager who oversees the property and gardening team and is available on call for facility matters. Planned and reactive maintenance systems are in place and maintenance requests are generated through the Sway (Summerset</p>

		<p>way) on-line system (property services requests). All electrical equipment has been tested and tagged. Clinical equipment has had functional checks/calibration annually. Hot water temperatures have been tested and recorded monthly with readings between 42-45 degrees Celsius. Preferred contractors for essential services are available 24/7.</p> <p>Corridors are wide in all areas to allow residents to pass each other safely. There is safe access to all communal areas and outdoor areas. There is outdoor seating and shade. The external areas are well maintained.</p> <p>The caregivers and registered nurses (interviewed) state they have all the equipment required to provide the care documented in the care plans.</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>There are adequate numbers of toilets and showers with access to a hand basin and paper towels. There are mobility bathrooms/toilets near rooms that do not have an ensuite. The majority of rooms have ensuite facilities. There are communal mobility bathrooms available in each wing and close to lounge/communal areas. The care apartments include a bathroom, kitchen and dining/lounge area.</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>Residents rooms are spacious and allow care to be provided and for the safe use and manoeuvring of mobility aids. Mobility aids can be managed in ensuites and communal toilets and bathrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment,</p>	FA	<p>There is a café, dining room and large lounge area adjacent to the care apartments on the ground floor. All residents and/or family can use the café dining and seating area. There is also another dining and lounge area for rest home residents in serviced apartments on the ground floor and level two. On level one, there is</p>

<p>Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>		<p>a kitchenette, large dining area and large lounge areas. There is a quiet lounge area available and there are seating areas along the corridors to allow residents to rest. There are two family/whānau lounges.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. There is a large laundry area which has a dirty to clean work flow with an entry and exit door. There are dedicated housekeeping staff on duty seven days a week. Cleaning trolleys sighted were well equipped and are kept in designated locked cupboards when not in use. External (chemical provider) and internal audits monitor the effectiveness of laundry and cleaning processes. Residents interviewed reported satisfaction with the cleaning and laundry service.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>There are emergency and disaster manuals to guide staff in managing emergencies and disasters. Emergencies, first aid and CPR are included in the mandatory in-service programme. There is a first aid trained staff member on every shift. Summerset at Wigram has an approved fire evacuation plan dated 2 September 2016 and fire drills occur six monthly. Smoke alarms, sprinkler system and exit signs are in place. The service has alternative cooking facilities (BBQ), and a generator available in the event of a power failure. There are civil defence kits located on each level in the facility and stored water. Call bells were evident in residents' rooms, lounge/dining 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>General living areas and resident rooms are appropriately heated and ventilated. Residents' rooms are heated via under floor heating. The communal living areas are heated and cooled via ceiling heating/cooling systems. All rooms have external windows with plenty of natural sunlight.</p>

<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The 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 has a signed job description. The infection control programme is linked into the quality management system and reviewed annually at head office in consultation with infection control officers. The facility meetings include a discussion of infection control matters and the infection control team meets monthly.</p> <p>Visitors are asked not to visit if they are unwell. Influenza vaccines are offered to residents and staff.</p> <p>Wigram experienced a norovirus outbreak in May 2017. Notifications to public health and CDHB and appropriate documentation including infection log, education sessions for staff, meeting minutes and an outbreak debrief were sighted for the outbreak.</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>	FA	<p>The infection control officer has completed on line infection control training. The infection control officer also attended external training. The infection control committee includes a representative from each department. The infection control committee meets monthly and infection events are forwarded to head office for benchmarking.</p> <p>The facility has access to an infection control nurse specialist at the DHB, an external infection control consultant, public health, laboratory, GPs and expertise within the organisation.</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</p>	FA	<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 2016. The infection control policies link to other documentation and cross reference where appropriate.</p>

practical, safe, and appropriate/suitable for the 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	<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. Ongoing training occurs annually as part of the training calendar set at head office. There is also an infection control board in the staff room that includes trends and education information.</p> <p>Resident education occurs as part of providing daily cares. Care plans include ways to assist staff in ensuring this occurs.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<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 the infection control committee and clinical/quality meetings. Areas for improvement are identified and corrective actions are developed and followed up. The facility is benchmarked against other Somerset facilities of comparable size and benchmarking results are fed back to the infection control officer and used to identify areas for improvement. Infection control audits are completed and corrective actions are signed off (sighted). Surveillance results are used to identify infection control activities and education needs within the facility.</p> <p>The service has evidenced improved outcomes for residents with a total of only seven UTIs in 2017 YTD.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There are policies around restraints and enablers. There were four residents requiring the use of a restraint and no residents using an enabler at the time of audit. Staff receive training around restraint minimisation that includes annual competency assessments.</p> <p>Caregivers interviewed described interventions to minimise restraint use including checking that all residents' needs such as toileting or wanting a drink are met regularly, checking every resident they are responsible for before going on a break and physically notifying the caregiver covering their break that they are going on a break.</p>
<p>Standard 2.2.1: Restraint approval and processes</p>	FA	<p>The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator (clinical nurse lead) and for staff are documented and understood. The restraint</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>approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements.</p>
<p>Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>PA Low</p>	<p>A restraint assessment tool was not fully completed for two of four residents requiring an approved restraint for safety. The restraint coordinator in partnership with the RNs, GP, resident and their family/whānau, undertakes assessments. Restraint assessments are based on information in the care plan, resident/family discussions and observations.</p> <p>Ongoing consultation with the resident and family/whānau are evident. Two of four hospital-level residents where restraint was in use (lap belts and bed rails), were selected for review and contained completed assessments. The completed assessments considered those listed in 2.2.2.1 (a) - (h).</p>
<p>Standard 2.2.3: Safe Restraint Use Services use restraint safely</p>	<p>PA Low</p>	<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 and family and the GP. The use of restraint is linked to the residents' care plans. Internal restraint audits measure staff compliance in following restraint procedures. Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Monitoring is documented on a specific restraint monitoring form, but does not already reflect the actual times monitoring occurred, evidenced in four resident files where restraint was being used.</p> <p>A restraint register is in place providing an auditable record of restraint use and is completed for all residents requiring restraints and enablers.</p>

<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations are conducted monthly as part of the restraint committee meeting. A review of four resident files identified that evaluations are up-to-date.</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 minimisation programme is discussed and reviewed at the monthly restraint meetings, attended by the restraint coordinator (clinical nurse lead), RNs and HCAs. Meeting minutes include (but are not limited to) a review of the residents using restraints or enablers, updates (if any) to the restraint programme, and staff education and training. Regular internal audits of restraint practices are also completed.</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 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	PA Moderate	<p>Twelve of fourteen medication charts and signing sheets reviewed evidenced that medications had been prescribed and administered as per policy. However, one paper medication signing sheet for a respite resident evidenced gaps in the medication signing sheet where medication was not able to be evidenced to be administered as prescribed. The GP had not updated one (rest home) electronic medication chart to reflect that the resident no longer self-administers all medications.</p>	<p>(i)The medication chart for one hospital respite resident did not evidence that inhalers had been administered as prescribed.</p> <p>(ii)The GP had not updated the medication chart for one rest home resident to</p>	<p>(i)Ensure that medications are administered as prescribed.</p> <p>(ii)Ensure that medication charts are updated to reflect current medication being self-administered and those which staff are required to</p>

			reflect that the staff store and administer prescribed 'as required' benzodiazepine medication.	administer.  60 days
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA Moderate</p>	<p>Five of seven resident care plans reviewed documented the required level of support and interventions to achieve the resident's goals or desired outcomes.</p>	<p>(i) The initial support plan completed for one respite (hospital) resident did not provide guidance to staff on management of asthma and diabetes (link to 1.3.12.1).</p> <p>(ii) For one hospital resident requiring the use of a restraint the care plan did not document the frequency of monitoring required when the restraint is in use.</p>	<p>(i-ii) Ensure that care plans document the interventions or level of support required to meet the identified goal or desired outcome.</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> <ul style="list-style-type: none"> <li>(a) Any risks related to the use of restraint;</li> <li>(b) Any underlying causes for the relevant behaviour or condition if known;</li> <li>(c) Existing advance directives the consumer may have made;</li> <li>(d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;</li> <li>(e) Any history of trauma or abuse, which may have involved the consumer being held against their will;</li> <li>(f) Maintaining culturally safe practice;</li> <li>(g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);</li> <li>(h) Possible alternative intervention/strategies.</li> </ul>	PA Low	Two of four restraint files sampled contained completed restraint assessments.	The assessment for one of four restraint files was not able to be located and a second assessment had not been fully completed.	<p>Ensure a comprehensive assessment is completed for each resident using restraint.</p> <p>90 days</p>
<p>Criterion 2.2.3.4</p> <p>Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:</p> <ul style="list-style-type: none"> <li>(a) Details of the reasons for initiating the restraint, including the desired outcome;</li> <li>(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;</li> <li>(c) Details of any advocacy/support offered, provided or facilitated;</li> <li>(d) The outcome of the restraint;</li> <li>(e) Any injury to any person as a result of the use of restraint;</li> <li>(f) Observations and monitoring of the consumer during the restraint;</li> </ul>	PA Low	In four files sampled for residents using restraint the use of restraint and management of risks associated with restraint use were documented in the care plan. Three of the four care plans documented the frequency monitoring is required (link 1.3.5.2). Monitoring records are maintained but for some shifts the actual time of monitoring is not recorded. This is evidenced by all four residents with restraints being documented as monitoring and cares happening at exactly the same time and a resident who uses a lap belt in the wheelchair and a bedrail when in bed had overnight monitoring times written	Monitoring records do not accurately reflect the monitoring that has occurred.	<p>Ensure restraint monitoring records are an accurate reflection of the monitoring interventions.</p> <p>90 days</p>

(g) Comments resulting from the evaluation of the restraint.		for both restraints.		
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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.