

Summerset Care Limited - Summerset on Summerhill

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 on Summerhill
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 15 February 2018 End date: 16 February 2018
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	41

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 on Summerhill provides rest home and hospital level care for up to 45 residents. On the day of the audit, there were 41 residents.

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 service is managed by a village manager and a care centre manager. 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. The residents and relatives interviewed spoke positively about the care and support provided.

This audit identified an improvement required around documented interventions.

The service has achieved continuous improvement ratings around good practice, planned activities and infection surveillance.

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.		All standards applicable to this service fully attained with some standards exceeded.
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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. An advocate from Age Concern attends resident's meetings. 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 the community.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Summerset on Summerhill implements a quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to a number of meetings including monthly quality improvement meetings. Annual 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.

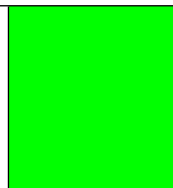
Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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The service has assessment processes and resident's needs are assessed prior to entry. There is a comprehensive pack available for residents and families/whānau at entry. Assessments, resident care plans, and evaluations were completed by the clinical nurse leader and registered nurses within the required timeframes. Risk assessment tools and monitoring forms were available and implemented. Resident care plans were individualised and included allied health professional involvement in resident care. A diversional therapist and team of volunteers implement an integrated activity programme. The activities meet the individual recreational needs and preferences of the resident groups. There are outings into the community and visiting guests/entertainers. There are medicine management policies in place that meets legislative requirements. Staff responsible for the administration of medications complete annual medication competencies and education. The general practitioner reviews the medication charts three monthly. The food service is contracted to an external company. Resident's individual dietary needs were identified and accommodated. Staff have attended food safety and hygiene training.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.

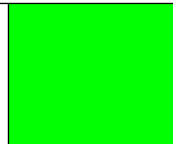


Standards applicable to this service fully attained.

There were documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Chemicals were stored safely throughout the facility. The building has a current warrant of fitness. Resident rooms and bathroom facilities are spacious. All communal areas within the facility are easily accessible. The outdoor areas are safe and easily accessible and provide seating and shade. The service has implemented policies and procedures for civil defence and other emergencies and six-monthly fire drills are conducted. There is a first aid trained staff member on duty 24 hours. Housekeeping/laundry staff maintain a clean and tidy environment. 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.

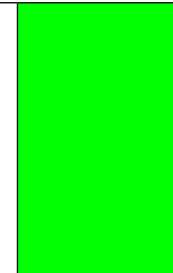


Standards applicable to this service fully attained.

Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort. The service currently has six residents assessed as requiring the use of restraint and six requiring enablers. Staff receive regular education and training on restraint minimisation. Restraint assessments, monitoring and evaluations occur. The restraint committee meets and reviews restraint use frequently.

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 officer (registered nurse) is responsible for coordinating and providing education and training for staff. The infection control officer has completed training. The infection control manual outlined the scope of the programme and included a comprehensive range of policies and guidelines. The infection control officer uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This included audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Somerset facilities.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	2	47	0	1	0	0	0
Criteria	3	97	0	1	0	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
<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 eleven staff (seven caregivers, two registered nurses (RN), one recreational therapist and one diversional therapist) confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Seven residents (five rest home and two hospital level) and six relatives (two rest home and four hospital) 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 were discussed with residents and families on admission. Written general and specific consents were evident in the seven resident files (five hospital level including one emergency respite care, one under chronic medical illness contract and one under 65 years of age and two rest home level of care). Verbal consent is identified for wound photographs. Caregivers and the clinical nurse leader interviewed confirmed consent is obtained when delivering cares. Resuscitation orders had been appropriately signed by the resident and GP. The service acknowledges the resident is for resuscitation in the absence of a signed directive by the resident. Advance care plans were signed for separately. Discussion with family members identifies that the service actively involves them in decisions that affect their relative's lives. Admission agreements for permanent and short-stay residents were sighted.</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	Residents are provided with a copy of the Code on entry to the service. Residents interviewed confirmed they are aware of their right to access independent advocacy services and advocacy pamphlets are available at reception. Discussions with relatives confirmed the service provided opportunities for the family/enduring power of attorney (EPOA) to be involved in decisions. The resident files include information on residents' family/whānau and chosen social networks.
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. Activities programmes included opportunities to attend events outside of the facility including activities of daily living, for example, shopping and attending cafés, and restaurants. Interviews 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>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	The organisational complaints policy stated that the village manager has overall responsibility for ensuring all complaints (verbal or written) are fully documented and investigated. There is an electronic complaint's register that included relevant information regarding the complaint. Documentation included follow-up letters and resolution were available. The number of complaints received each month is reported monthly to staff via the various meetings. There have been 26 complaints made since the last audit. All the complaints documentation included follow-up letters and resolutions were completed within the required timeframes. Twenty-two of the twenty-six complaints made were around food services, corrective actions have been implemented and followed-up, resulting in a change of the preferred food provider (November 2017). A complaints procedure is provided to residents within the information pack at entry. Feedback forms are available for residents/relatives in various places around the facility.
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	The service provides information to residents that include the Code, complaints and advocacy. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Residents and relatives interviewed identified they were well informed about the Code of Rights. Three monthly resident/family 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>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Staff interviewed were able to describe the procedures for maintaining confidentiality of resident records, residents' privacy and dignity. House rules and a code of conduct are signed by staff at commencement of employment. Contact details of spiritual/religious advisors are available. Resident files include cultural and spiritual values. Residents and relatives interviewed reported that residents are able to choose to engage in activities and access community resources. There is an elder abuse and neglect policy and staff education and training on abuse and neglect last occurred in July 2017.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>Summerset on Summerhill has a Māori health plan that includes a description of how they achieve the requirements set out in the contract. 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. They value and encourage active participation and input of the family/whānau in the day-to-day care of the resident. At the time of the audit there was one resident that identified as Māori living at the facility. Māori consultation is available through the documented Iwi links (Whakapai Hauoroa). Staff interviewed were able to 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>	FA	<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 confirms values and beliefs are considered. Residents interviewed confirm 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>	FA	<p>Contracts and job descriptions include responsibilities of the position and ethics, advocacy and legal issues and staff sign a copy on employment. The orientation programme provided to staff on induction includes an emphasis on privacy and personal boundaries. 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 RNs 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>CI</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 leader. 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.</p> <p>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 that adhere to the Health & Disability Services Standards and all approved service standards are adhered to. There are implemented competencies for caregivers and RNs including but not limited to: insulin administration, medication, wound care and manual handling. RNs have access to external training. There is a family suite within the care centre which mostly caters for families of end of life residents.</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. Ten incident/accidents (eight hospital, and two rest home) forms reviewed, had documented evidence of family notification or noted if family did not wish to be informed. Family members interviewed also stated they are informed of changes in the health status of residents and incidents/accidents. Resident/relative meetings are held three monthly. The village manager and the care centre manager have an open-door policy. The service produces a newsletter for residents and relatives. Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The service has policies and procedures available for access to interpreter services for residents (and their family/whānau). If residents or family/whānau have difficulty with written or spoken English, the interpreter services are made available.</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</p>	<p>FA</p>	<p>The service currently provides care for up to 45 residents at hospital (geriatric and medical) and rest home level care in the care centre. On the day of audit, there were 41 residents which included nine rest home residents and 32 hospital residents (including one resident on a healthcare recovery (DHB) contract, one resident on a chronic medical illness (CMI) funded contract, one younger person with disabilities (YPD) and one resident on respite). All 45 beds in the care centre are dual-purpose. All other residents were under the aged related residential care (ARRC) contract.</p>

<p>consumers.</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. Summerset on Summerhill has a site-specific business plan and goals for 2018. There is a full evaluation at the end of the year. The 2017 business plan evaluation was sighted.</p> <p>There is a retirement village attached as part of the complex with overall management of the site provided by the village manager. The village manager has been in the position for five years. She is supported by an experienced care centre manager who has also been in the role for five years. A regional operations manager and regional quality manager are also available to support the facility and staff. The regional quality manager was present during the days of the audit.</p> <p>Village managers and care centre managers attend annual organisational forums and regional forums over two days. The village manager and care centre manager have 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>	<p>FA</p>	<p>During a temporary absence, the care centre manager will cover the village manager's role. The regional operations manager and regional quality manager provide 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>	<p>FA</p>	<p>Summerset on Summerhill 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. The Summerset group has a 'clinical audit, training and compliance' calendar. The calendar schedules the training and audit requirements for the month and the care centre manager reports completion of requirements. Summerset on Summerhill reporting to head office includes (but not limited to): complaints, staff turnover, meetings held, audits, quality indicators for infections, incidents and accidents, health and safety and projects.</p> <p>There is a meeting schedule including monthly quality improvement meetings that includes discussion about clinical indicators (eg, incident trends, infection rates). The service has developed a quality control pathway (documented plan) that enables staff to have an understanding of the required quality</p>

		<p>systems as well as the opportunity to have input and receive feedback. Caregivers' meetings are held fortnightly. Clinical/RN meetings are held monthly, health and safety, infection control and restraint are reported monthly with meetings occurring three monthly. There are other facility meetings held such as kitchen and activities. An annual residents/relatives survey completed (September 2017) reports 90% overall satisfaction feedback of experience being either good or very good. 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.</p> <p>Monthly and annual analysis of results is completed and provided across the organisation. There are monthly accident/incident benchmarking reports completed by the care centre manager that break down the data collected across the rest home and hospital. Somerset has a data tool "Sway" (the Somerset Way). Sway is integrated and accommodates the data entered. There is a health and safety and risk management programme in place including policies to guide practice. The village manager is the health and safety officer (interviewed) and has completed level three health and safety training. Five other health and safety representatives have also completed level three health and safety training in their role. There is a current hazard register. Health and safety internal audits are completed. Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Incident and accident data has been collected and analysed. Discussions with the service confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Ten resident related incident reports for January 2018 were reviewed (eight falls, one skin tear and one bruising). Each event involving a resident reflected a clinical assessment and follow-up by a RN. All falls have a documented post-fall assessment. 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>
<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</p>	FA	<p>There are human resources policies to support recruitment practices. A list of practising certificates is maintained. Eight staff files (one care centre manager, one clinical nurse leader, one RN, three caregivers, one diversional therapist, and one property manager) were reviewed and all had relevant documentation relating to employment. Performance appraisals had been completed annually for those staff who have been employed for over 12 months. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme includes documented competencies and induction checklists (sighted in staff files</p>

requirements of legislation.		<p>reviewed). Staff interviewed were able to describe the orientation process and believed new staff were orientated well to the service.</p> <p>There is an annual education plan that is outlined on the 'clinical audit, training and compliance calendar'. The 2017 education plan has been completed and the 2018 plan is being implemented. A competency programme is in place with different requirements according to work type (eg, caregivers, RNs and kitchen). Core competencies are completed, and a record of completion is maintained on staff files as well as being scanned into 'Sway'. Staff interviewed were aware of the requirement to complete competency training and commented that the current education programme was comprehensive and interesting. The service has five of ten RNs trained in interRAI.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. There are clear guidelines for increase in staffing depending on acuity of residents. The village manager and care centre manager work 40 hours per week from Monday to Friday and are available on call for any emergency issues or clinical support. The clinical nurse leader works full time from Sunday to Thursday. Interviews with staff, residents, and relatives confirmed that staffing levels are sufficient to meet the needs of residents.</p> <p>There are three wings in the care centre. Wing A has 11 residents (seven hospital and four rest home residents), wing B has 15 residents (13 hospital and two rest home residents) and wing C has 15 residents (12 hospital and three rest home residents). There are two RNs on duty on the morning shift, two on the afternoon shift, and one on duty on the night shift. The RNs are supported by an adequate number of caregivers. There are six caregivers on the morning shift (two in each wing), six on the afternoon shift (two in each wing) and two on the night shift (wing B and C). 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>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are protected from unauthorised access by being locked away in the nurses' stations. Other residents or members of the public cannot view sensitive resident information. Entries in records are legible, dated and signed by the relevant caregiver or RN.</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. 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. 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>FA</p>	<p>There are medicine management policies and procedures that align with recognised standards and guidelines for safe medicine management practice in accordance with the Medicines Care Guide for Residential Aged Care 2011. The RNs are responsible for the administration of medications. Staff complete competencies for the checking and witnessing of medications as required. Medication education has been completed annually. All medications (in robotic rolls) were evidenced to be checked on delivery with any discrepancies fed back to the supplying pharmacy. There were no self-medicating residents.</p> <p>All medications were stored correctly. The medication fridge is monitored weekly. The service has been involved in a medication optimisation project (1.1.8.1). Fourteen resident medication charts on the electronic medication system and corresponding medication administration sheets were reviewed. The medication charts had photograph identification and allergy status recorded. Staff recorded the time and date of 'as required' medications. All as required medications had an indication for use. All medication charts had been reviewed by the GP 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>The service has a contracted company for the provision of all meals on-site. The kitchen is adjacent to the dining room with meals served directly to residents from a bain marie in the kitchen. There is a six-week rotating summer menu that has been approved by the organisational dietitian. The menu also has a vegetarian option. Recent improvements include all freshly made soups and the use of shaped moulds to improve the presentation of pureed meals. Resident likes/dislikes and preferences are known and accommodated with alternative meal options. Texture modified meals, fortified foods,</p>

		<p>protein drinks and diabetic desserts are provided. The chef receives a dietary profile for each resident.</p> <p>The qualified chef (interviewed) is notified of any changes to resident's dietary requirements and resident preferences. The fridge, freezer, end-cooked food temperatures and last meal serving temperatures are taken and recorded. All foods are stored correctly, and date labelled. Cleaning schedules are maintained. Staff were observed wearing correct personal protective clothing. The chemical provider completes a functional test on the dishwasher monthly. Staff working in the kitchen have food handling certificates and completed chemical safety training. Residents have the opportunity to feedback on meals through direct feedback, resident meetings and surveys.</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>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. The reason for declining entry would be if the service was unable to provide the level of care required or if there were no beds available.</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>The initial assessment including the risk assessment tools (as applicable) are developed with information received on admission, including discussion with the resident and relatives and referring agency, for all long-term and short-stay residents. Risk assessments are reviewed six monthly as part of the interRAI assessment. Outcomes of risk assessment tools and interRAI assessment are used to identify the needs, supports and interventions required to meet resident goals of permanent residents. The interRAI assessment tool has been utilised six monthly for all long-term residents including the younger person and CMI resident. The resident under 65 years and the respite care were not required to have an interRAI assessment.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Care plans for long-term residents describe the individual support and interventions required to meet the resident goals. The care plans reflect the outcomes of risk assessment tools and the interRAI assessment. Care plans demonstrate service integration and include input from allied health practitioners. The respite care and health recovery resident had an initial assessment and initial support plan in place (link 1.3.6.1). The health recovery person had a recovery plan developed by the DHB team with resident goals. The service reported to the DHB team weekly on progress towards the resident goals. Short-term care plans were in use for changes in health status. These are evaluated regularly and either resolved or if an ongoing problem added to the long-term care plan. There is</p>

		documented evidence of resident/family involvement in the care planning process. Residents/relatives interviewed confirmed they participate in the care planning process.
<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>	PA Low	<p>When a resident's condition changes, the RN initiates a review and if required a GP or nurse specialist consultation. Relatives interviewed state their relative's needs are met and they are kept informed of any health changes. There was documented evidence in the resident files of family notification of any changes to health including infections, accidents/incidents, and medication changes. Residents interviewed state their needs are being met. Not all interventions had been documented for three residents funded under non-ARCC contracts.</p> <p>Adequate dressing supplies were sighted. Initial wound assessments with ongoing wound evaluations and treatment plans were in place for six residents with wounds. Photographs and evaluations demonstrate progress to healing. Two chronic wounds are linked to the long-term care plans. There is wound nurse specialist advice and support available at the DHB. There were no pressure injuries on the day of audit. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed.</p>
<p>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>	CI	<p>The service employs a registered full-time diversional therapist (DT) five days a week. The DT is on the executive DT board and an assessor. She is supported by a recreational officer (also a caregiver) three days a week to coordinate and implement the seven-day week programme. The programme is varied and provides many group and individual activities to meet the hospital and rest home resident's recreational preferences and interests. On one day of the week there are two activity persons offering a choice of activities to attend. One-on-one contact is made daily with residents who are unable to or choose not to participate in group activities. Activities include (but not limited to); exercises and walks, word games and quizzes, board games, stories and reminiscing, music and movies. The DT has successfully implemented weekly cognitive stimulation therapy for hospital residents with dementia. There are a ladies and men's group that meet weekly to participate in activities, outings of interest to the group.</p> <p>There are twice weekly outings in the facility van that accommodates a wheelchair. There are a higher number of hospital residents with declining mobility unable to maintain their former links in the community, so the community groups come into the care centre including guest speakers, entertainers, pre-school children, Christian fellowship visitors, SPCA and pet therapy. Festive occasions and events are celebrated. The younger person has an individualised activity plan based on their preferences and interests. For short-term residents the DT makes contact with the</p>

		resident/family and invites them to attend activities offered. Resident meetings and surveys provide an opportunity for residents to feedback on the programme. The DT is involved in the multidisciplinary review which includes the review of the activity plan. The DT works Saturdays and Sundays and has the opportunity to meet with the visiting families.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	There is evidence of resident and family involvement in the review of long-term resident care plans. All initial care plans of the permanent residents were evaluated by the RNs within three weeks of admission. Written evaluations for long-term residents were completed six monthly or earlier for resident health changes. There is evidence of multidisciplinary (MDT) team involvement in the reviews including input from the GP, care staff, DT and any allied health professionals involved in the resident's care. Families are invited to attend the MDT review and asked for input if they are unable to attend. Short-term care plans sighted have been evaluated by the RN. The GP completes three monthly reviews.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	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.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Safety datasheets were readily accessible for staff. Chemicals were stored safely throughout the facility. Personal protective clothing was available for staff and seen to be worn by staff when carrying out their duties on the day of audit. Relevant staff have completed chemical safety training.
Standard 1.4.2: Facility	FA	The building is two levels with the care centre on the ground floor and staff only areas upstairs. The

<p>Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>building has a current building warrant of fitness that expires on 24 July 2018. A full-time property manager of the care centre and villas (also available on-call) oversees a team of property assistants (two groundsmen). The property manager has completed a health and safety course level three and first aid. Planned and reactive maintenance systems are in place and maintenance requests are generated through the on-line system and closed-off when completed or paper-based system after-hours. All electrical equipment has been tested and tagged. Clinical equipment has had functional checks/calibration annually.</p> <p>Hot water temperatures have been tested and recorded monthly with readings below 45 degrees Celsius (as sighted on the on-line system). Essential contractors are available 24 hours. 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. Outdoor areas provide seating and shade. The external areas are well maintained. There are three internal wings of bedrooms. Environmental improvements include ongoing refurbishment of resident rooms and communal areas. The caregivers (interviewed) state they have all the equipment required to safely 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>All rooms are single. One wing of resident rooms has either own or shared ensuites with privacy locks. All other resident rooms have hand basins and access to adequate numbers of shared shower/toilet facilities with privacy locks. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. There are adequate numbers of communal toilets located near the communal areas with privacy locks. Resident interviewed confirmed the care staff respect their 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>There is adequate room to safely manoeuvre mobility aids and transferring equipment such as a hoist, as needed for cares and transfer of residents. The doors are wide enough for ambulance trolley access. Residents and families are encouraged to personalise their units as viewed on the day of audit.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p>	FA	<p>Communal areas within the facility include a large main lounge and adjacent dining room. There is also a conservatory lounge/additional dining area in the main communal area. In one wing there is a sun lounge and a family room with tea/coffee making facilities. There are several seating alcoves</p>

<p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>		<p>within the facility. The communal areas and outdoor patios and courtyards are easily accessible for residents.</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. All linen and personal clothing is laundered on-site during the night by a dedicated laundry person. There is a defined clean/dirty area with an entry and exit door. The laundry facility is well equipped, and all machinery has been serviced regularly.</p> <p>There are dedicated cleaning staff on duty daily. Cleaning trolleys sighted were well equipped and are kept in designated locked cupboards when not in use. There are safety datasheets and product sheets available. All chemicals are dispensed through an auto dispenser. Internal audits monitor the effectiveness of laundry and cleaning processes. The chemical provider monitors the laundry and cleaning processes for effectiveness. Cleaning and laundry staff have completed chemical safety training.</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 duty 24 hours. Appropriate training, information, and equipment for responding to emergencies is provided. There is an approved evacuation plan. Fire evacuations are held six monthly and the last drill was completed 31 January 2018. Smoke alarms, sprinkler system and exit signs are in place. The civil defence kit is readily accessible and is checked every six months.</p> <p>The facility is well prepared for civil emergencies and has emergency lighting, a store of emergency water and a gas BBQ for alternative cooking. There is a generator available on-site. Emergency food supplies, sufficient for three days, are kept in the kitchen. There is a store cupboard of supplies necessary to manage a pandemic/outbreak. During the tour of the facility, residents were observed to have easy access to the call bells and residents interviewed stated their bells were answered in a timely manner. The facility is secured at night.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with</p>	<p>FA</p>	<p>Visual inspection evidences that the residents have adequate natural light in the bedrooms and communal rooms, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. There is underfloor heating.</p>

adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.		
<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 (RN) has been in the role for two months and has been orientated and supported in the role by the care centre manager. Both have completed on-line infection control modules in 2017. The infection control programme is linked into the quality management system and reviewed annually at head office by the national infection control person who is a regional quality manager and RN. The quality and staff meetings include a discussion of infection control matters. Visitors are asked not to visit if they are unwell. Influenza vaccines are offered to residents and staff. Hand sanitisers are available throughout the facility.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The infection control officer has completed an on-line DHB infection control course. The care centre manager has also completed an on-line training session. There is an infection control committee that meets monthly in conjunction with the RN meetings. A representative from caregivers and housekeeping, attend the committee meeting. The facility has access to an infection control nurse specialist at the DHB, DHB wound nurse, public health, laboratory, GPs and the national infection control person at head office.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of</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 are reviewed regularly by the national infection control person/RN at head office. The infection control policies link to other documentation and cross reference where appropriate.</p>

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 are infection control meeting minutes and quality data including graphs displayed for staff. Resident education occurs as part of providing daily cares. Care plans can 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. The monthly infection events, trends and analysis are reviewed by management and data is forwarded to head office for benchmarking. Areas for improvement are identified and corrective actions developed and followed-up. 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>There has been one norovirus outbreak in January 2018. The public health was notified, and the service commended for its efforts in containing the outbreak.</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. The service currently has six residents assessed as requiring the use of restraint (bed rails only) and six requiring enablers (five bed rails and one lap belt). Their care plans are up-to-date and provide the basis of factual information in assessing the risks of safety and the need for restraint. Ongoing consultation with the resident and family/whānau is also identified. Residents voluntarily request and consent to enabler use. Staff receive regular education and training on restraint minimisation.</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</p>	FA	<p>A restraint approval process and a job description for the restraint coordinator are in place. The restraint coordinator role is delegated to the care centre manager. All staff are required to attend restraint minimisation training annually.</p>

(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>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	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. A restraint assessment tool meets the requirements of the standard. Three residents' files where restraint was being used were selected for review. Each file included a restraint assessment and consent form that was signed by the resident's family. Restraint use is linked to the resident's care plan and is regularly reviewed.
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	A restraint register is in place. The register identifies the residents that are using a restraint, and the type(s) of restraint used. The restraint assessment identified that restraint is being used only as a last resort. The restraint assessment and ongoing evaluation of restraint use process includes reviewing the frequency of monitoring residents while on restraint. Monitoring forms are completed when the restraint is put on and when it is taken off.
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	Restraint use is reviewed monthly by the restraint committee during restraint meetings. The review process includes discussing whether continued use of restraint is indicated.
<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>	FA	The service reviews restraint use as part of its internal audit processes. The results of the restraint audit are discussed at the monthly quality meetings and any corrective actions identified are actioned through this forum.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Low	There are a number of monitoring forms and charts available for use including (but not limited to) pain monitoring, blood sugar levels, weight, wound evaluations, food and fluid intake. Short-term care plans describe interventions required to support long-term resident needs for changes to health status, however, there were no documented interventions for clinical risk for residents under other DHB contracts.	(i) There were no documented falls prevention strategies or seizure management plan for one hospital resident under the CMI DHB contract. (ii) There were no pressure injury preventions documented for one emergency respite hospital resident identified as high risk for pressure injuries. (iii) There were no documented falls prevention strategies for one health recovery resident identified as high risk of falls. (iv) There were no monitoring instructions or reports on the circulation status of a leg in plaster.	(i)-(iii) Ensure there are documented interventions in place for identified clinical risk. (iv) Ensure monitoring is completed where needed 90 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>The service was chosen by the DHB in 2016 to pilot a project to reduce polypharmacy to below 10 medications for residents of the main GP. The pilot project has been successful in reducing 50% of resident’s medication to below 10.</p>	<p>The medication optimisation project aimed at reducing medications to below 10 for the main GP. There has been ongoing consultation between the DHB project team, GP, clinical manager and DHB geriatrician. The project commenced in 2016 and throughout 2017 residents were closely monitored by the general practitioner (GP) and nurse practitioner (NP) as they reduced their medications. The GP met with residents and relatives to discuss the benefits and monitoring in place to reduce the number of medications being taken. Some initiatives taken included reducing paracetamol to three times a day with a fourth dose as required. Laxative medication was able to be reduced through use of natural. The service will continue to liaise with the other residents GPs to reduce the number of medications used for their residents.</p>
<p>Criterion 1.3.7.1</p> <p>Activities are</p>	CI	<p>The DT trained in cognitive stimulation therapy through study at the DHB. The programme was initiated at Summerset</p>	<p>The programme specifically addresses the need to have cognitive stimulation on a consistent and regular basis. A small group of eight residents meet weekly in the small lounge and include activities such as</p>

<p>planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>		<p>on Summerhill, focused on hospital level residents with dementia. The DT then promoted the programme at study days at the DHB and DT conferences. The introduction of stimulating activities to small groups of residents has been beneficial in reducing resident anxiety and agitation and has been acknowledged throughout the Somerset group with winning awards.</p>	<p>aromatherapy for sense of smell, using textiles for creations, crafts made of a variety of textiles, flowers and displays, use of instruments to bring rhythm to music, babies and pre-school children visits, pet therapy, visual aids with touch and colour, adult colouring, aqua painting, floral art, doll therapy and reminiscing. Due to the success of the cognitive stimulation for the specific residents some activities have broadened out to be part of the men's and ladies group. The DT works Saturdays and Sundays and receives positive feedback from the families of residents who attend the cognitive stimulation therapy group. The survey satisfaction rate for activities was predominantly excellent and very good from all respondents.</p>
<p>Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>	<p>CI</p>	<p>The service identified an area for improvement around reducing the rate of urinary tract infections (UTI). An action plan was developed that was successful in reducing UTIs.</p>	<p>An action plan was developed in October 2016 to reduce of urinary tract infections (UTI). Staff were informed and educated around the importance of hygiene, hydration rounds and early reporting of any resident signs and symptoms of UTI. Fluids were offered in a variety of forms including jellies and milkshakes. Urinary and faecal incontinence was monitored. The use of laxatives was monitored with GP review to reduce faecal incontinence and reduce faecal contamination, as identified in urine microbiology results. Over the October 2016 to October 2017 (annual surveillance period) there have been 3.72 UTIs which is well below the lower limit of the organisational benchmark limits for UTIs.</p>

End of the report.