

Summerset Care Limited - Summerset By The Park

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Summerset Care Limited
Premises audited:	Summerset By The Park
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 21 March 2017 End date: 21 March 2017
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:	60

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 the Park provides rest home and hospital level care for up to 111 residents including rest home level care in 55 serviced apartments. On the day of the audit there were sixty residents, including seven rest home residents in serviced apartments. The service is managed by a relief village manager and a care centre manager. The residents and relatives interviewed spoke positively about the care and support provided.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, family, management and staff.

The relief 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.

Seven of the nine shortfalls identified at the previous audit have been addressed. These were around complaints process, communicating quality results with staff, corrective action plans, health and safety monitoring, incident/accident investigations, nursing assessments, medication management, and food management. Further improvements continue to be required around nursing interventions and wound documentation.

This surveillance audit identified improvements required around aspects of activities 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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Residents are provided with information they need on entry to the service and this is regularly updated. Interviews with residents and family confirms they are provided with adequate information and that communication is open.

Communication records are maintained in each resident record. Residents are informed of the complaints process and there are policies and procedures in place to investigate complaints. Complaints reviewed are responded to and closed out in a timely manner.

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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There is a relief facility manager, care centre manager and a clinical nurse leader who provide operational management, including clinical management for the service.

There is an implemented quality and risk management programme that is fully implemented. Adverse, unplanned, and untoward events are documented by staff and reviewed by relevant managers. All aspects of the quality programme are discussed at relevant meetings. The health and safety programme meet current legislative requirements.

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

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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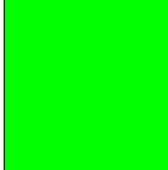
The service has assessment processes and resident's needs are assessed prior to entry. There is a well-developed information pack available for residents and families/whānau at entry. Assessments, resident-centred care plans, interventions and evaluations were completed by the registered nurses within the required timeframes. Risk assessment tools and monitoring forms were available and implemented. Resident-centred care plans were individualised and evidenced allied health professional involvement in the resident's care.

An occupational therapist is currently overseeing the activities programme with assistance from an experienced caregiver. Together they coordinate and implement an integrated activity programme based on resident preference and participation. The activities meet the individual recreational needs and includes community involvement, entertainment and visits into the community.

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.
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A current building warrant of fitness is posted in a visible location.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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There are policies around restraint minimisation and use of enablers. The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety. There are no residents using enablers and three using restraint on audit day.

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.

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

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	15	0	1	2	0	0
Criteria	0	39	0	1	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)
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 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms for lodging informal complaints (feedback) and formal complaints are readily available. A suggestions box is held at reception.</p> <p>Information about the complaints process is provided on admission. Interviews with residents and family members confirmed their understanding of the complaints process. Staff interviewed were also able to describe the process around reporting complaints.</p> <p>An electronic complaints register is maintained. Five complaints for 2018 were reviewed. All were fully investigated by the care centre manager with evidence of resolution of issues recorded and documentation confirming that the complainant was satisfied with the outcome of the investigation also documented. The improvement required at the certification audit has been met.</p> <p>The pre-audit feedback from the district health board requested follow up and information around a complaint in 2016 lodged with the Health and Disability Commission (HDC). A letter from HDC dated September 2017 requests that the results of an investigation into the complaint be forwarded by October 2017. The result of the investigation was sent to HDC and the service is waiting for a final outcome from HDC. There are no coroner's inquest reports open and no deaths referred to the coroner since the last audit as confirmed by the relief village manager. Information requested by the coroner has been forwarded and the facility has not heard anything back from the coroner to date.</p>

		Complaints received are discussed at relevant meetings.
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Accident/incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/enduring power of attorney and the resident of any accident/incident that occurs. Evidence of contact being maintained with families including when an incident or care/health issue arises, is documented on the accident/incident forms reviewed. Interviews with four hospital families confirm that they are kept informed.</p> <p>Interpreting services are available from an external provider and through staff and families.</p> <p>The information pack is available in large print and this could be read to residents. Residents sign an admission agreement on entry to the service.</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>	FA	<p>Summerset by the Park is certified to provide rest home and hospital (geriatric and medical) level care in their care facility. There are 55 dual purpose beds on level three; one room designated as a respite bed (rest home level of care) on level two; and 27 apartments certified as being able to be used for residents requiring rest home level of care (across level two and level three).</p> <p>On the day of the audit, there were 19 residents requiring rest home level care (including two identified as using respite services) and 41 requiring hospital level care (including one resident on an ACC contract). Seven of the residents requiring rest home level of care are residing in serviced apartments. Summerset by the Park holds medical certification for their hospital residents.</p> <p>The organisation is guided by a philosophy, vision and values. A 2017 operations business plan is reviewed quarterly throughout the year. A 2018 business plan is documented, and this includes goals, business requirements and benefits and measures of success.</p> <p>A relief village manager with appropriate and applicable experience is responsible for the retirement village until the village manager vacancy is filled. The relief village manager has been in the role since January 2018 and has over 20 years' experience in aged care.</p> <p>The care centre manager has been in the role since November 2017. They have over 15 years' experience in aged care including management previously in another Summerset service. They are supported by an experienced clinical nurse leader.</p> <p>The care centre manager and clinical nurse leader have both attended a minimum of eight hours of professional development activities related to managing an aged care facility as confirmed through review of staff records.</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>The quality and risk management programme is established through the Somerset head office. Quality management is overseen by the organisation's regional quality manager and a clinical quality manager who responds to complaints received at a head office level. The regional quality manager is supporting the new care centre manager and visits approximately two times a week currently.</p> <p>Policies and procedures reflect evidence of regular reviews as per the document control schedule. New and/or revised policies are made available for staff to read and sign that they have read and understand the changes. Somerset is in the process of reviewing policies and procedures. The village manager and care centre manager are held accountable for their implementation.</p> <p>There is monthly collating of quality and risk data. Data is collated and benchmarked against other Somerset facilities to identify trends (nationally and regionally). A review of data for 2018 indicates that there is a low rate when compared against expected key performance indicators and against other like facilities. The CNL, restraint coordinator and the care centre manager have access to all the data and analysis of data.</p> <p>There are regular meetings held. A review of meeting minutes confirms that quality data and results are being communicated to staff. Staff also confirm that they are informed of any corrective actions and quality improvements. There are monthly resident and family meetings facilitated by the occupational therapist.</p> <p>An annual resident and family satisfaction survey has been completed. The outcome of the survey identified that those who responded were very satisfied with the service provided.</p> <p>An annual internal audit schedule is being implemented with audits completed as per the schedule from June 2017 to current. In addition to monthly internal audits, the regional quality manager completes six-monthly facility audits. A review of the audit completed in October 2017 indicated that there were findings particularly around care plans, staff records and quality processes. A corrective action plan was documented with resolution confirmed through the internal audit programme. A review of internal audits confirms that corrective action plans are completed with evidence of resolution and sign off by the village manager.</p> <p>Corrective actions are also developed when opportunities for improvements are identified through other means such as complaints and satisfaction survey results. A review of the complaints process confirms that corrective action plans are documented with evidence of resolution of issues. Falls prevention strategies are being implemented. This includes the implementation of interventions on a case-by-case basis to minimise future falls. Sensor mats and physiotherapy services are utilised.</p> <p>There is a health and safety plan for the service that is linked to the strategic plan. The goals are reviewed through the health and safety meeting. The health and safety programme is overseen by a health and safety officer (property manager) and is supported by a health and safety team and a national health and safety officer. The monthly health and safety meeting reviews any hazards or other health and safety issues and allows for discussion of issues. There is a contractor induction programme in place. The village manager reviews the register monthly as part of reporting to the health and safety meetings with a review of meeting</p>
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		<p>minutes confirming this.</p> <p>The improvements required at the previous certification shortfalls in meeting minutes around discussion of quality information, signing off corrective actions and documentation of hazards have been met.</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>The service collects a comprehensive set of data relating to adverse, unplanned, and untoward events, which is linked to the quality and risk management system. Immediate actions taken are documented on accident/incident forms. The forms are reviewed and investigated by the care centre manager or clinical leader. These reviews are signed off in a timely manner. The improvement required at the certification audit has been met.</p> <p>Discussions with the relief village manager, the care centre manager and the regional quality manager confirm their awareness of statutory requirements in relation to essential notification. The service provided copies of emails confirming that the district health board and HealthCERT had been informed of changes in the care centre manager appointed in November 2017.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Job descriptions are in place for all relevant positions that describe staff roles, responsibilities and accountabilities. The practising certificates of nurses and visiting health professionals are kept on file and are current.</p> <p>Nine staff files reviewed (the care centre manager, two registered nurses, the clinical nurse leader, two caregivers, one laundry staff and a new occupational therapist) confirmed that there is a signed employment contract on file, a current job description and documentation of orientation and staff training.</p> <p>Annual performance appraisals for staff are up-to-date. Newly appointed staff complete an orientation that is specific to their job duties. Interviews with caregivers who cover the morning, afternoon and night shifts confirmed that the orientation programme included a period of supervision over three days.</p> <p>The service has a training policy and schedule for in-service education. The in-service schedule is implemented, and attendance is recorded. A system for determining staff competency is implemented. Competencies for registered nurses includes medication, syringe driver and insulin administration.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive</p>	FA	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. The care centre manager and clinical nurse leader work five days a week (Monday – Friday).</p> <p>The care facility on level three is rostered with two registered nurses (or one registered nurse and one enrolled</p>

<p>timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>nurse) on all shifts; 11 caregivers on the morning shift (seven on a short shift); seven caregivers on the afternoon shift (three on a short shift) and two caregivers overnight. The care apartments are supported by a caregiver on each shift.</p> <p>Separate staff complete laundry and cleaning duties. Staff report that staffing levels and the skill mix is safe and they have ample time to complete tasks. Interviews with residents and families confirm that they felt there was sufficient staffing. The roster can be changed in response to resident acuity. Registered nurses interviewed confirm that they understand when to call emergency services and to contact managers after hours if needed.</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. Registered nurses, enrolled nurse and senior caregivers responsible for the administration of medications have completed annual medication competencies and attended medication education. Registered nurses have completed syringe driver training. The service has fortnightly robotic rolls delivered which are checked by the RN against the medication chart. Any discrepancies are fed back to the supplying pharmacy. The service uses an electronic medication system. There were no residents self-medicating on the day of audit. The temperature of the medication fridge is monitored at least weekly. All eyedrops had been dated on opening. The clinical nurse leader conducts weekly monitoring of the administration of medication documentation and use of 'as required' medications. All medication charts sampled identified indications for use for 'as required' medications. The previous shortfall has been addressed.</p> <p>Ten resident medication charts on the electronic medication system were reviewed (four rest home and six hospital). The charts had photograph identification and allergy status recorded. Staff recorded the time and date of 'as required' medications. The effectiveness of 'as required' medication was recorded on the electronic system.</p> <p>Nine of ten medication charts reviewed identified that the GP had reviewed the medication chart three-monthly. One chart sampled was for a respite resident and did not require review. The service does not store vaccines.</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</p>	<p>FA</p>	<p>A newly contracted company provides meals on-site. The service has a registered food service plan. There is a seasonal and rotating menu approved by the dietitian. The menu includes resident preferences. The food services manager (interviewed) is notified of any changes to resident's dietary requirements. Resident likes/dislikes and preferences are known and accommodated with alternative meal options. Food is delivered in hot boxes to the dining room kitchenette where meals are served from the Bain Marie. Special requests and alternative meals are plated and labelled. Texture modified meals, fortified foods, protein drinks, dairy free and diabetic desserts are provided. The cook receives a dietary profile for each resident.</p>

<p>service delivery.</p>		<p>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. The facility fridges, chiller and freezer have temperatures recorded at least daily. End cooked food temperatures and serving temperatures are recorded for each meal. Foodstuffs in the fridge, freezer and pantry evidenced dates of when they were initially opened or prepared. Dried goods such as herbs, spices and flour evidenced expiry dates or decanting dates. All foods are stored correctly, and date labelled. The previous partial attainment has been addressed.</p> <p>Staff working in the kitchen have food handling certificates and chemical safety training.</p> <p>Residents commented positively on the meals provided. The food service manager receives feedback from the head chef and from residents on meals. Resident meetings and surveys identify areas of improvement. The food services manager and chef receive feedback from meetings and surveys.</p>
<p>Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>The care plans in resident files sampled described the resident goals, supports and interventions required to meet desired goals as identified through assessments. The long-term care plan, completed within three weeks, records the resident's problem/need and objectives; however, not all interventions fully reflected the residents' needs. This previous partial attainment remains an area for improvement. Referrals are made to allied health professionals such as dietitian, speech language therapy and physiotherapy when required. Evidence of recommended interventions were sighted in care plans such as nutritional supplements and thickened fluids. Residents are seen by the GP three monthly or earlier when health needs indicate review. Care plans were evaluated for identified issues and were completed six-monthly, or as condition changed. Residents and families interviewed confirmed their involvement in the care planning process and multidisciplinary meetings. Short-term care plans are in use for short-term needs and changes in health status. There was evidence of allied healthcare professionals involved in the care of the resident.</p>
<p>Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Moderate</p>	<p>When a resident's condition changes, the RN initiates a review and if required a GP or nurse specialist consultation. The relatives interviewed stated their family member'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 (seven hospital and one rest home respite resident) stated their needs are being met.</p> <p>Adequate dressing supplies were sighted. Initial wound assessments with ongoing wound evaluations and treatment plans were in place for residents with seventeen wounds (eight skin tears, three skin lesions. one ulcer, two moisture wounds and three other). There were no current pressure injuries. Evaluation comments were documented at each dressing change to monitor the healing progress. Not all wounds were redressed at the frequency documented in the management plan. The RN and clinical nurse leader confirmed there is a</p>

		<p>wound nurse specialist available who has been involved in pressure injury management. Continued improvement is required around aspects of wound management.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management and continence products identified for day use, night use and other management. Specialist continence advice is available as needed.</p> <p>There are a number of monitoring forms and charts available for use including (but not limited to): pain monitoring; restraint; blood sugar levels; weight; wound evaluations; food and fluid intake; repositioning charts; and neurological observations. RNs review the forms/charts and completed risk assessments for any changes to health status.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>PA Low</p>	<p>The service employs an occupational therapist (OT) for 12 hours per week to maintain oversight of the activities programme and to provide training support for the activities team. The diversional therapist position was vacated in late January and a replacement has not yet been employed. An experienced care staff member is currently implementing the activities programme Monday to Friday with support from other care staff and oversight from the OT. The programme is implemented across seven days for both rest home and hospital level of care residents. The activity team attend Summerset training sessions and the regional DT group.</p> <p>A diversional therapy needs, cultural and communication assessment is completed shortly after admission. The diversional therapy care plan is documented within three weeks and goals and outcomes are reviewed six-monthly with monthly DT progress note entries. Not all documentation has been complete as required.</p> <p>The programme is planned a month in advance and has 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 into the community. Other activities include a variety of exercises, newspaper reading, housie, bowls, reminiscing, crafts and happy hour. Community visitors include weekly entertainers, church services, volunteers from the independent apartments, Duke of Edinburgh students and mum and baby visits. The activity team ensure daily contact is made with residents who choose to stay in their rooms and for those residents in serviced apartments. Care centre residents are invited to participate in village activities.</p> <p>Residents are encouraged to maintain their former community links. The service has a wheelchair van for the rest home and hospital resident outings.</p> <p>Regular meetings and annual surveys provide an opportunity for residents to feedback on the programme.</p>
<p>Standard 1.3.8:</p>	<p>FA</p>	<p>There is evidence of resident and family involvement in the review of resident-centred care plans. All initial care</p>

<p>Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>		<p>plans reviewed had been evaluated by the registered nurses within three weeks of admission. Written evaluations were completed six-monthly or earlier for resident health changes in all files reviewed. There is evidence of multidisciplinary (MDT) team involvement in the reviews including input from the GP and any allied health professionals involved in the resident's care. Families are invited to attend the MDT review and asked for input if they are unable to attend. Short-term care plans sighted have been evaluated by the RN. The GP completes three-monthly reviews.</p>
<p>Standard 1.4.2: 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 building has a current building warrant of fitness that expires in May 2018. Hot water temperatures have been tested and recorded monthly with readings maintained below 45 degrees Celsius. Reactive and preventative maintenance occurs. There is adequate equipment available including (but not limited to) hoists, pressure reducing mattresses, roho cushions, lifting belts, wheelchairs and individual walkers. RN's interviewed stated there was sufficient equipment and if more was required they could ask and this was provided by the organisation.</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 that includes a surveillance procedure, process for detection of infection, infections under surveillance, outbreaks and quality and risk management. Infection events are collected monthly and entered into an 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 Summerset facilities of similar 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. Surveillance results are used to identify infection control activities and education needs within the facility. There has been one outbreak in November 2017 which was well documented and managed. Public health authorities were notified in a timely manner.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service has documented systems in place to ensure the use of restraint is actively minimised. There are three residents using hospital level of care using a restraint and no residents using an enabler.</p> <p>Staff interviews confirms that guidance has been given on restraint minimisation and safe practice, enabler use and prevention and/or de-escalation techniques. Policies and procedures include definitions of restraint and enablers that are congruent with the definition in NZS 8134.0. Staff education including assessing staff competency on restraint and the use of enablers has been provided within the last year.</p>

<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>The service has documented systems in place to ensure the use of restraint is actively minimised. There are three residents using hospital level of care using a restraint and no residents using an enabler.</p> <p>Staff interviews confirms that guidance has been given on restraint minimisation and safe practice, enabler use and prevention and/or de-escalation techniques. Policies and procedures include definitions of restraint and enablers that are congruent with the definition in NZS 8134.0. Staff education including assessing staff competency on restraint and the use of enablers has been provided within the last year.</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)
Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	PA Moderate	Overall the care plans in resident files sampled described the resident goals, supports and interventions required to meet desired goals as identified through assessments One resident with weight loss was reviewed. There were dietary interventions documented. One resident with pain was reviewed, interventions and management were included in the LTCP. Five resident files documented with mobility requirements and three residents identified as high-pressure injury risk included appropriate interventions.	The care plan for one rest home resident identified a requirement for daily blood sugar levels, but medical notes documented blood sugar levels were to be taken three times a day. This was not included in the care plan.	Ensure the care plans reflect interventions to support all current needs and instructions. 60 days
Criterion 1.3.6.1 The provision of services and/or interventions are	PA Moderate	Wound assessment and management plans are documented and implemented, however, not all dressings were reviewed at the documented frequency. Allied health	(i) One rest home resident required blood glucose recordings three times a day as requested by the GP. However, this was not completed. (ii) Four of seventeen	(i) Ensure health professionals instructions are fully implemented; (ii)

<p>consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>		<p>professionals are involved in the care of the resident including the GP and podiatrist.</p>	<p>wounds reviewed did not have dressings completed at the frequency documented in the wound management plan.</p>	<p>Ensure wounds are redressed at the frequency documented in the wound management plan.</p> <p>90 days</p>
<p>Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	<p>PA Low</p>	<p>Residents care plans are documented for residents using the assessments and DT goals and outcomes as a basis for the care plan. Monthly progress notes documentation was evidenced as completed and up to date in one of the four long-term residents' files sampled. Six-monthly reviews of goals and outcomes have been completed for two of three residents who required evaluations (one was a respite resident and one had not been at the service for six months).</p>	<p>(i) The respite resident had not had any documented contact from the activities staff since admission. (ii)The monthly progress notes entries have not been completed for three of four long-term resident files. (iii)The six-monthly review of goals and outcomes have not been reviewed for one of three residents who required it. (iv) The goals and outcomes had been documented for one resident admitted within the last six months, but this was not dated.</p>	<p>(i) Ensure all residents are assessed by activities staff within 48 hours. (ii) Ensure monthly diversional therapy progress notes are documented for all residents. (iii) Ensure goals and outcomes are reviewed six-monthly. (iv) Ensure all DT documentation is clearly dated.</p> <p>90 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.