

# Summerset Care Limited - Summerset by the Park

---

## Introduction

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

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

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

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

The specifics of this audit included:

<b>Legal entity:</b>	Summerset Care Limited
<b>Premises audited:</b>	Summerset by the Park
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 12 February 2019      End date: 13 February 2019
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	56

# Executive summary of the audit

---

## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Summerset by the Park provides rest home and hospital level care for up to 111 residents including rest home level care in 55 serviced apartments. On the day of the audit there were 56 residents, including six rest home residents in serviced apartments. The residents and relatives interviewed spoke positively about the care and support provided.

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

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

This certification audit identified that improvements are required in relation to communication of adverse events, business planning, quality, timeframes, implementation of care and care planning.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Some standards applicable to this service partially attained and of low risk.
--	--	---

The facility provides care in a way that focuses on the individual resident. There is a Māori health plan and cultural safety policy supporting practice. Cultural assessment is undertaken on admission and during the review process. The service functions in a way that complies with the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and related services is readily available to residents and families. Policies are available that support residents' rights. Care plans accommodate the choices of residents and/or their family. Complaints processes are being implemented and complaints and concerns are managed and documented. Residents and family interviewed verified ongoing involvement with community.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
---	--	--

Summerset by the Park has a documented quality and risk management system. Key components of the quality management system link are reported monthly to head office. Annual surveys and monthly resident meetings provide residents and families with

an opportunity for feedback about the service. Quality performance data on incidents, infections and internal audit results is collated monthly. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care. There is a staffing policy in place.

## Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
---	--	---

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

Medication administration aligns with legislative requirements and guidelines. The registered nurses, enrolled nurse and senior caregivers are responsible for administration of medicines via an electronic system. Annual education and medication competencies are completed. The medicine charts were reviewed at least three monthly by the general practitioner.

The diversional therapist and occupational therapist provide and implement a varied activity programme. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical, cultural and cognitive abilities and preferences for each resident group. Residents expressed satisfaction with the programme.

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

## 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 one person on duty at all times with a current first aid certificate. Housekeeping/laundry staff maintain a clean and tidy environment. There is plenty of natural light in all rooms and the environment comfortable with adequate ventilation and heating.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		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. Staff receive regular education and training on restraint minimisation. There were four residents requiring the use of a restraint and one using an enabler at the time of audit.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
---	--	--

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

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	44	0	3	3	0	0
<b>Criteria</b>	0	95	0	3	3	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0



# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<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 seven care staff (four caregivers, three registered nurses (RN) including the clinical nurse leader and one diversional therapist) confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Ten residents (three rest home and seven hospital level of care) and six relatives (one rest home and five 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</p>	FA	<p>Informed consent processes were discussed with residents and families on admission. Written general and specific consents were evident in the eight resident files (five hospital level and three rest home level of care including one rest home resident in the serviced apartment). Written general consents are obtained on admission. Caregivers and the RNs interviewed confirmed consent is obtained when delivering cares. Resuscitation orders had been appropriately signed by the resident and general practitioner. The service acknowledges the resident is for resuscitation in the absence of a signed directive by the resident. Copies of enduring power of attorney were available and had been activated for residents deemed incompetent to make decisions. The electronic care plan includes a section on end of life wishes/cares which had been completed for the eight long-term resident files reviewed. The care plan template is utilised for all residents.</p> <p>Discussion with family members identified that the service actively involves them in decisions that affect their</p>

consent.		relative's lives. Admission agreements for permanent residents were sighted.
Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	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 included information on residents' family/whānau and chosen social networks.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community.	FA	Interviews with residents and relatives confirmed that visiting can occur at any time. Family members were seen visiting on the day of the audit. Key people involved in the resident's life are documented in the care plans. Discussions with residents and relatives verified that they are supported and encouraged to remain involved in the community. Summerset by the Park staff support ongoing access to community. Activities programmes included opportunities to attend events outside of the facility including activities of daily living. Relatives and friends are encouraged to be involved with the service and care as evidenced by attendance at monthly resident meetings.
Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld.	FA	<p>The organisation has a complaints policy that describes the management of the complaints process. There are complaints forms available at reception that provide links to HDC advocacy services. Complaints forms are available from reception and booklets describing the complaints process are published and available in public areas. Interviews with residents and families demonstrated an understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints.</p> <p>There is an electronic complaint register that is held by the unit manager. Verbal and written complaints are documented. All complaints reviewed had noted investigation, timeframes, corrective actions when required and were signed off as resolved. Results are fed back to complainants but are not documented as being reported to staff (link 1.2.3.6). There were ten complaints in 2018 including one from the DHB in June 2018 and three complaints received in 2019 (year to date). Complaint documentation included follow-up letters and resolutions were completed within the required timeframes. Two complaints remain open, pending further investigation. Complainants (external) have been contacted and documentations confirmed processes are being followed.</p> <p>The pre-audit feedback from the district health board requested follow-up and information around a complaint initially lodged with the Health the Health and Disability Commission (HDC) in 2015 with further additions in 2017 and 2018. An investigation was undertaken, and a final outcome was received In June 2018. The</p>

		complaint was largely substantiated. A number of recommendations were implemented and proof of the last of these requirements was forwarded on 14 December 2018. Recommendations including additional training and support in care planning and family communication, dementia training, improved utilisation of mental health services for the older person and Summerset wide policy changes. These recommendations have been implemented.
Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights.	FA	The service provides information to residents that includes the Code, complaints and advocacy. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Residents and relatives interviewed identified they are well informed about the Code of Rights. Monthly resident meetings provide the opportunity to raise concerns. An annual residents/relatives survey is completed. Advocacy and Code of Rights information is included in the information pack and are available at reception.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	Staff interviewed could describe the procedures for maintaining confidentiality of resident records, resident's privacy and dignity. Contact details of spiritual/religious advisors are available. Resident files include cultural and spiritual values. Residents and relatives interviewed reported that residents can choose to engage in activities and access community resources. There is an elder abuse and neglect policy and staff education and training on abuse and neglect has been provided in June 2018.
Standard 1.1.4: Recognition Of Māori Values And Beliefs  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.	FA	Summerset by the Park has a Māori health plan that includes a description of how they achieve the requirements set out in the contract. There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. At the time of audit there were no residents who identified as Māori. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with disability and other community representative groups as requested by the resident/family. Cultural needs are addressed in the care plan. Staff interviewed could describe how they can ensure they meet the cultural needs of Māori.

<p>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 family/whānau as appropriate/able are invited to be involved. Individual beliefs or values are further discussed and incorporated into the care plan. Six-monthly multidisciplinary team meetings occur to assess if needs are being met. Family are invited to attend. Discussion with relatives confirmed values and beliefs are considered. Residents interviewed confirmed that staff consider their culture and values.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Staff job descriptions include responsibilities and staff sign a copy on employment. The quality improvement meetings occur monthly and include discussions on professional boundaries and concerns as they arise. Management provide guidelines and mentoring for specific situations. Interviews with the village manager, relief care centre manager, clinical nurse leader and registered nurses confirmed an awareness of professional boundaries. Caregivers discussed professional boundaries and attended training in December 2018.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>Residents and relatives interviewed spoke very positively about the care and support provided. Staff have a sound understanding of principles of aged care and stated that they feel supported by the village manager, relief care centre manager and clinical nurse lead. All Summerset facilities have a master copy of policies which have been developed in line with current accepted best practice and are reviewed regularly. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff. There is a quality improvement programme that includes performance monitoring against clinical indicators and benchmarking against like services within the group, as well as other external aged care providers.</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 by the park that adhere to the Health &amp; Disability Services Standards and all approved service standards are adhered to. There are implemented competencies for caregivers and registered nurses including but not limited to: insulin administration, medication, wound care and manual handling. RNs have access to external training.</p>
<p>Standard 1.1.9:</p>	PA Low	<p>Residents and family members stated they were welcomed on entry and were given time and explanation about services and procedures. Family members interviewed also stated they are informed of changes in the health</p>

<p>Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>status of residents and incidents/accidents, however documentation does not always support this is delivered in a timely manner. Resident/relative meetings are held monthly. The village manager and the relief 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. Two current residents with limited English receive interpreter services arranged by the village.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>PA Low</p>	<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 22 residents requiring rest home level care and 34 requiring hospital level care. Six 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. All residents are under the age-related contract.</p> <p>The Summerset Group Limited Board of Directors have overall financial and governance responsibility and there is a company strategic business plan in place. The organisation is guided by a philosophy, vision and values. The site specific 2018 operations business plan developed in consultation with the village manager and regional operations manager (ROM) includes goals, business requirements and benefits and measures of success. The quality plan is documented in January each year, however quarterly reviews and an annual review have not occurred as scheduled in 2018.</p> <p>The village manager has been in the current role at Summerset by the Park since April 2018. The village manager is supported by an experienced relief care centre nurse manager following the resignation of the previous care centre manager. The care centre manager has been in the position for one week and has been involved in management roles in aged care for many years. The care centre manager is supported by the clinical nurse lead who has been in the role for three weeks. Village managers and care centre managers attend annual organisational forums and regional forums over two days. There is a regional operations manager and quality manager who are available to support the facility and staff. The village manager has attended at least eight hours of leadership professional development relevant to the role.</p>
<p>Standard 1.2.2: Service Management</p>	<p>FA</p>	<p>During a temporary absence, the care centre manager will cover the manager's role. The regional operations manager and the clinical quality manager provide oversight and support. The audit confirmed the service has</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>operational management strategies 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>PA Moderate</p>	<p>Summerset by the Park has a documented quality and risk management system. There are policies and procedures being implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed on a regular basis. The content of policy and procedures are detailed to allow effective implementation by staff.</p> <p>The Summerset group has a 'clinical audit, training and compliance' calendar. The calendar schedules the training and audit requirements for the month and the care centre completes a 'monthly report to the regional quality manager. The report includes (but is not limited to): meetings held, induction/orientation, audits, competencies and projects and is forwarded to head office as part of the ongoing monitoring programme. The relief care home manager is implementing improvements in communication of quality data and corrective action planning.</p> <p>A range of data (eg, falls, skin tears, other incidents, infections complaints, staff incidents, medication errors) are collected, collated and analysed monthly by the care centre manager. Results are shared on line with head office and graphs are placed on the staffroom noticeboard. An internal audit programme schedule includes monthly audits which have been completed as planned since September 2018. Prior to this time, audits were implemented but did not always follow the schedule. Corrective actions raised as a result, evidenced these have been completed as required.</p> <p>The annual resident survey was completed in September 2018. Results show a decline in overall satisfaction from 97% in 2017 to 73% in 2018. Satisfaction has decreased in all areas from the previous year. Corrective actions were not raised and there was no evidence that satisfaction survey results were shared with staff, residents or family.</p> <p>There is a health and safety and risk management programme in place including policies to guide practice. The village manager is one of the health and safety representatives (interviewed). Falls prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.</p> <p>There is a meeting schedule including monthly combined quality and health and safety and weekly</p>

		management meetings which have been held as scheduled. Registered nurse meetings include infection control and restraint and are held monthly. Caregivers meetings are held weekly. There are other facility meetings held such as maintenance and activities. The meetings minutes include clinical indicators (eg, incident trends, infection rates), internal audits, complaints etc as standard agenda items, however minutes do not evidence discussion of quality data.
<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. Section 31 notifications have been made for pressure injuries. Twelve resident related incident reports for January and February 2019 were reviewed (eight falls, two skin tears, one wandering and one other category). All reports and corresponding resident files reviewed evidenced that appropriate clinical care has been provided following an incident, however not all family notifications were made in a timely manner (link 1.1 9 1). 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 requirements of legislation.</p>	FA	<p>There are human resources policies to support recruitment practices. A list of practising certificates is maintained. Eight staff files (one clinical nurse lead, two RNs, one diversional therapist, and four caregivers) 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 files of newly appointed staff). Staff interviewed were able to describe the orientation process and believed new staff were adequately orientated to the service. There is an annual education plan that is outlined on the 'clinical audit, training and compliance calendar'. The plan is being implemented. Additional training has been delivered to both RNs and care staff in response to identified needs including (but not limited to) dementia, family communication, care planning and EPOA understanding for RNs. A staff engagement improvement plan is being implemented for 2019. A competency programme is in place with different requirements according to work type (eg, caregivers and registered nurse). Core competencies are completed, and a record of completion is maintained on staff files and on an electronic human resources database.</p> <p>Staff interviewed were aware of the requirement to complete competency training and stated they were actively encouraged to achieve New Zealand qualifications through Careerforce training. There are 34 permanent caregivers employed with most, other than newly appointed staff, having attained a minimum of level two or</p>

		level three.
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>The village manager and care centre manager work 40 hours per week Monday to Friday and are available on call for any emergency issues or clinical support. The clinical nurse lead works full time Sunday to Thursday. In the care centre, there is an RN on duty 24/7. On morning and afternoon shifts a second enrolled nurse or RN is also rostered. There are nine caregivers on morning shifts (four long shifts and five short shifts), eight on the afternoon shift (four long and four short) and two on night shift.</p> <p>The RN on duty provides oversight to the rest home residents in the serviced apartments. One caregiver is on duty in the serviced apartments on a morning shift, an afternoon shift and a night shift to assist the six rest home residents.</p> <p>A diversional therapist is rostered Monday to Friday, eight hours a day in the care unit. She is supported by an occupational therapist who works 9.00 am to 1.00 pm, three days a week.</p> <p>Staffing levels and skills mix policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery. A staff availability list ensures that staff sickness and vacant shifts are covered. Caregivers interviewed confirmed that staff are replaced when off sick.</p> <p>Interviews with residents and relatives confirmed that staffing levels are sufficient to meet the needs of residents.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident files were appropriate to the service type. Residents entering the service have all relevant initial information recorded (link 1.3.3). Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access by being securely stored electronically. Care plans were digitally signed (and dated) by a registered nurse. Progress note entries are dated and digitally signed by the relevant care assistant or registered nurse including designation. Individual resident files demonstrate service integration. There is an allied health section that contained general practitioner notes and the notes of allied health professionals and specialists involved in the care of the resident.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a</p>	FA	<p>Residents' entry into the service is facilitated in a competent, equitable, timely and respectful manner. All residents are admitted with a care needs level assessment completed by the need's assessment and service coordination team prior to admission. Admission information packs available on the services for rest home and hospital level care, are provided for families and residents prior to admission or on entry to the service. Eight admission agreements reviewed aligned with contractual requirements of the Age Related Residential Contract.</p>



<p>competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>		<p>Exclusions from the service are included in the admission agreement.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>Planned exits, discharges or transfers were coordinated in collaboration with the resident and family to ensure continuity of care. There were documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The procedure includes a transfer/discharge form and copy of prescription chart. The residents and their families were involved for all exit or discharges to and from the service.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>There are policies and procedures in place for safe medicine management, including self-administration, that meet legislative requirements. An electronic medicine management system is implemented to ensure residents receive medicines in a safe and timely manner. Clinical staff who administer medications (RNs and senior caregivers) have been assessed for competency on an annual basis and attend annual medication education. Staff sign for the administration of medications on medication sheets within the electronic medication system.</p> <p>The facility uses a four-week robotic system. Medication received from pharmacy is checked on delivery against the medication chart by an RN. All medications (including apartment residents) are stored safely in the care centre treatment room. The medication fridge is maintained within the acceptable temperature range. All eye drops, and ointments were dated on opening. There were three residents self-medicating on the day of audit. A self-medication competency had been reviewed three monthly.</p> <p>Sixteen medication charts were reviewed. Photo identification and allergy status are recorded. 'As required' medications were administered as indicated and outcomes recorded in the electronic medication system. The GP had reviewed medication charts 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</p>	<p>FA</p>	<p>All meals at the service are prepared and cooked on site by external contractors. The head chef oversees the overall management of the kitchen and ordering of supplies. The head chef is supported by the assistant manager from head office (present on the day of audit), senior chefs, an intern chef and morning and afternoon kitchenhands. All kitchen staff are trained in safe food handling and receive ongoing training. The food control plan was verified 26 June 2018.</p> <p>There is a rotating seasonal menu which has been reviewed by the contracted dietitian. Menus can be adjusted to meet resident preferences. Breakfasts are served in the care centre from the satellite kitchen. The main</p>

<p>service delivery.</p>		<p>meal is at dinner with a lighter meal at midday. Meals are transported in dishes in scan boxes and served from the bain mairé in the care centre. Serviced apartment rest home residents are able to receive meals in the care centre or serviced apartment dining room or in their room. Meals are plated and labelled in the main kitchen for those residents having meals in rooms.</p> <p>On admission, the registered nurse completes a dietary profile and a copy is given to the kitchen. The RN updates the profiles with any changes to dietary requirements and notifies the head chef. Likes, dislikes and food allergies are accommodated, and the menu provides options including gluten free food. Modified meals are provided. Staff were observed serving and assisting residents with their lunchtime meals and drinks.</p> <p>The service records all fridge and freezer, cooking, cooling and re-heating temperatures daily. All stored food was dated. Resident meetings and surveys allow the opportunity for resident feedback on the meals and food services generally. The chef assists with serving meals and receives verbal feedback on the meals. Residents and family members interviewed indicated satisfaction with the food service.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>The reasons for declining entry would be if the service is unable to provide the level of care required or there are no beds available. Management would communicate directly with the referring agencies and family/whānau as appropriate if entry was declined.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>Personal needs information is gathered during admission from discharge summaries, medical notes, home care assessments and from discussions with the resident, relative and other allied health professionals involved in the resident care. The information gathered, forms the basis of resident goals and objectives. InterRAI assessments are completed on admission (link 1.3.3.3) and used to inform the care plan (link 1.3.5.2). Appropriate risk assessments had been completed for individual resident risks/concerns.</p>
<p>Standard 1.3.5: Planning</p>	<p>PA</p>	<p>The long-term care plans reviewed included resident's goals, however not all plans included all supports and interventions to meet the resident's assessed needs. The InterRAI assessment and other assessments tools</p>

<p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>Moderate</p>	<p>undertaken do not always inform the development of the resident's care plan. Residents and their family/whānau interviewed reported that they are involved in the care planning and review process. Eight resident long-term care plans reviewed evidenced multi-disciplinary team (MDT) involvement. Short-term care plans were evident in use for short-term needs and changes in health status. These were reviewed regularly and signed off as resolved or if an ongoing problem added to the care plan. There was evidence of allied health care professionals including podiatrist, dietitian and physiotherapist involved in the care of the resident.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Low</p>	<p>In the eight resident files reviewed it was noted that when a resident's condition alters, the registered nurse initiates a review and if required a GP or nurse specialist consultation. Discussions with families and notifications were documented in the family/whānau correspondence in the resident files.</p> <p>Adequate dressing supplies were sighted in the treatment room. Wound assessments, treatment and evaluations were in place for residents with current wounds and skin tears. There was one facility acquired unstageable pressure injury. The RNs interviewed were able to describe the referral process for a wound care nurse specialist and dietitian if required. The wound nurse has been involved in the pressure injury. There are adequate resources and the RNs, and care staff could describe pressure injury interventions and management.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. Residents are weighed monthly or more frequently if weight is of concern. Nutritional requirements and assessments are completed on admission.</p> <p>Acute care plans document appropriate interventions to manage short-term changes in health. There are number of monitoring forms and charts utilised to monitor a resident's progress.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The occupational therapist (12 hours per week) and diversional therapist (40 hours per week) plans for the provision of the integrated rest home and hospital activities programme Monday to Friday. Summerset has a group DT who oversees activities staff and the programme and provides support for staff. There are three days a week where both the DT and OT are on during the week, which allows for one-on-one time to be spent with residents who are unable to participate or choose not to join in group activities. The OT completes initial activity and cultural assessments for all residents. Volunteers from the village provide activities in the weekends including pamper sessions, board games, chats and room visits. Duke of Edinburgh students assist in the implementation of group and individual resident activities. Church services are also held in the weekends. Rest home residents in serviced apartments can choose to join the village or care centre activity programme.</p> <p>The programme is planned monthly and residents receive a copy of planned monthly activities in their rooms. Activities planned for the day were displayed on noticeboards around the facility. Activities include (but are not limited to); news and views, daily walks, exercises, board games, quizzes, indoor bowls, card games, yoga,</p>

		<p>mindful colouring and happy hours. Goals for 2019 are focused around evidence-based activities that increase the resident's quality of life. Several clubs have commenced and include cooking club, gardening club, arts club, music club, lady's afternoon and book club. New activities introduced include intergenerational activities with mums and bubs and pre-schoolers, SPCA pet visits, sing-along team, storytelling and time-slips and cinema afternoons. There are entertainers and outings into the community, scenic drives, mystery drives and "plane spotting".</p> <p>A diversional therapy plan has been developed for each individual resident based on assessed needs. Residents are encouraged to join in activities that are meaningful and are encouraged to participate in community activities including integration with the village activities. Residents were observed being encouraged and participating in activities on the days of audit.</p> <p>Resident and family meetings with an advocate and annual surveys provide a forum for feedback relating to activities as well as resident verbal feedback. Residents and family members interviewed discussed enjoyment in the programme and the diversity offered to all residents.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The initial care plans for long-term residents were evaluated by the RN. All eight resident files reviewed had a long-term care plan in place, however six of eight long-term care plans had not been evaluated six monthly (link 1.3.3.3). Care plan evaluations have been completed. Two residents had not been at the service long enough for a review. Short-term care plans sighted in resident care plans had been evaluated and resolved as resident goals had been met or if an ongoing problem added to the long-term care plan. Family had been invited to attend multi-disciplinary meetings to discuss the care plan review and informed of any changes if unable to attend. There were at least three monthly reviews by the GP.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Referral to other health and disability services is evident in the resident files sampled. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There is evidence of residents that have been referred to the dietitian, podiatrist, wound care specialist and Mental Health services. Discussions with RNs confirmed that the service has access to a wide range of support.</p> <p>There are documented policies and procedures in relation to exit, transfer or transition of residents. The residents and the families are kept informed of the referrals made by the service.</p>

<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Safety data sheets were readily accessible for staff. Chemicals were stored safely throughout the facility. There was a locked external dangerous goods shed. Personal protective clothing was available for staff and seen to be worn by staff when carrying out their duties on the day of audit. There were two sluice rooms in the care centre with gloves, aprons and visors at the point of use. Relevant staff have completed chemical safety training.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building is three levels with the care centre on the third floor and serviced apartments on the first and second level. The building has a current building warrant of fitness that expires on 17 April 2019.</p> <p>A full-time property manager of the care centre and villas oversees a team of three property assistants and one groundsman. The property manager is a health and safety representative and completed health and safety course one, and site-safe certificate. Maintenance requests are generated through the on-line system and closed off when completed or paper-based system after-hours. There is a monthly maintenance plan that includes environmental, building and resident equipment checks. Electrical equipment has been tested and tagged. Clinical equipment including hoists and weigh scales, have been calibrated. Hot water checks in resident areas are checked monthly as part of the planned maintenance schedule. Essential contractors are available 24 hours.</p> <p>Corridors are wide in all areas to allow residents to pass each other safely. There is safe access to all communal areas and outdoor areas. Outdoor areas provide seating and shade. The external areas are well maintained.</p> <p>The caregivers (interviewed) stated 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</p>	<p>FA</p>	<p>All resident rooms, with the exception of one standard room have full ensuites. The one standard room has a hand basin and is located near a large shower/toilet. The communal shower/toilet is large enough to accommodate a shower trolley if required. There is a disabled toilet with privacy signs located near the communal areas. Resident interviewed stated the staff respected their privacy when attending to their personal cares.</p>

<p>toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>		
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All residents' rooms are spacious enough for residents to safely manoeuvre about with mobility aids. The resident rooms are spacious enough for the use of hoists for hospital level care residents. There is one double room, with all other rooms being single. Rooms viewed on the day of audit were personalised with the resident's adornments and furnishings.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Communal areas within the facility include a large main lounge and adjacent dining room. There is a family room available. There are several seating alcoves within the facility. A café is located adjacent to the kitchen and is open to residents and the public. The residents have access to the library. The communal areas and outdoor areas 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</p>	FA	<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 by a dedicated laundry person seven days a week. 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 cleaning cupboards when not in use. There are safety data sheets 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</p>

service is being provided.		effectiveness. Each resident room has a room cleaning schedule that is signed on completion. Cleaning and laundry staff have completed chemical safety training. Personal protective clothing is readily available.
<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>	FA	<p>Emergency and disaster policies and procedures, a pandemic plan and a civil defence plan are documented for the service. The education and training programme includes fire and security training, which begins during new staff orientation and ongoing through the internal training programme. Staff interviewed confirmed their understanding of emergency procedures. There is an approved evacuation plan for the service with six monthly fire drills completed. There are adequate civil defence supplies available in the event of a civil defence emergency including food, two 10,000 litre water tanks and equipment. The emergency lighting will run up to four hours and there is a backup generator on-site. There is a staff member on duty at all times with a current first aid certificate.</p> <p>A call-bell system is in place in all resident rooms and communal areas. Residents were observed in their rooms with their call-bells in close proximity.</p> <p>Surveillance cameras are situated at the main entrance, back door and main gates to the village. Entry is by intercom system and staff operation of the gates.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>Residents are provided with adequate natural light and safe ventilation in the resident rooms and communal areas. There is underfloor heating to all areas in the winter. Fans and air conditioning units were placed strategically throughout the care centre to cool the temperature. Residents had fans in their rooms.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and</p>	FA	<p>The infection control programme is appropriate for the size and complexity of the service. There is an infection control job description that includes responsibilities for the infection control coordinator. The infection control coordinator (registered nurse) has just commenced the role and has been orientated and supported in the role by the relieving care centre manager and by the national infection control person at head office. The infection control programme is linked into the quality management system and reviewed annually in November at head office by the national infection control person, who is a registered nurse.</p> <p>Visitors are asked not to visit if they are unwell. Influenza vaccines are offered to residents. Hand sanitisers</p>

visitors. This shall be appropriate to the size and scope of the service.		are available throughout the facility.
<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 coordinator will participate in monthly teleconferences “zoom” meetings with the infection control person at head office. The relieving care centre manager attended the last meeting by teleconference. An infection control committee is in the process of being formed with representatives from each area. The meeting will be held prior to the RN meeting. A new position has been created for a caregiver coach who will support the infection control coordinator in monitoring and supporting infection control practice on the “floor”.</p> <p>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 service provided.</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/registered nurse at head office. The infection control policies link to other documentation and cross reference where appropriate.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on</p>	FA	<p>The infection control coordinator is responsible for coordinating and providing education and training to staff. The orientation book includes specific training around hand washing competencies, standard precautions and outbreak management. Ongoing training occurs annually as part of the training calendar set at head office.</p>



infection control to all service providers, support staff, and consumers.		<p>Infection control information is posted on the staff noticeboard.</p> <p>Resident education occurs as part of providing daily cares. Care plans can include ways to assist staff in ensuring this occurs. Resident meetings include infection control measures that focus on seasonal illnesses, for example influenza and vaccinations and urinary tract infections and importance of fluids in warmer weather. Information is posted on the resident/visitor noticeboard.</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 entered into the VCare system which emails alerts to the infection control coordinator and relieving care centre manager. The infection control officer provides a monthly report of infections and relevant information to the management and facility meetings; however, meeting minutes do not reflect discussion around infection trends and analysis (link 1.2.3.6). The monthly infection events 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. Clinical indicators for all types of infections for the Summerset group and the facility are displayed in the staff room. Meeting minutes are available to staff.</p> <p>There have been no outbreaks.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There are policies around restraints and enablers. There were four residents requiring the use of a restraint and one resident using an enabler at the time of audit. Staff receive training around restraint minimisation that includes annual competency assessments.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure),</p>	FA	<p>The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator (registered nurse) and for staff are documented and understood. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements. Restraint authorisation is in consultation/partnership with the family, restraint coordinator and GP.</p>

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	<p>A restraint assessment tool is completed for residents requiring an approved restraint for safety. Suitably qualified and skilled staff, in partnership with the resident and their family/whānau, undertake assessments. Restraint assessments are based on information in the care plan, resident discussions and on observations of the staff. Ongoing consultation with the resident and family/whānau was evident. The files for three residents using restraint and one resident using an enabler were reviewed. The completed assessment considered those listed in 2.2.2.1 (a) - (h). Ongoing consultation with the family and staff is evident through the restraint review process.</p> <p>Falls risk assessments are completed six-monthly and interRAI assessment identifies risk and the need for restraint.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The service has a restraint approval process that is described in the restraint minimisation policy. Monitoring and observation is included in the restraint policy. The restraint coordinator is a registered nurse and is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint.</p> <p>Internal audits are completed three monthly, ensuring all restraint processes are completed as per the restraint policy and procedures. The restraint coordinator reports that each episode of restraint is monitored at predetermined intervals, depending on individual risk to that resident. Monitoring is documented on a specific restraint monitoring form (sighted).</p> <p>A restraint register is in place providing an auditable record of restraint use. This has been completed for all residents requiring restraints.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations occur monthly in the registered nurses meeting and six-monthly as part of the multi-disciplinary review for the resident on restraint. Families are included as part of this review. A review of three files of residents using restraints identified that evaluations were up-to-date.</p>

<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>At the monthly facility quality meetings, RN meetings, staff meetings and six-monthly restraint meetings, restraints are discussed and reviewed. Any incidents of emergency physical restraint (which have not occurred) would also be reviewed at these meetings. Meeting minutes include a review of the restraint and challenging behaviour education and training programme for staff. Staff receive orientation in restraint use on employment. There is internal benchmarking.</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 1.1.9.1 Consumers have a right to full and frank information and open disclosure from service providers.	PA Low	All incidents are recorded in an electronic management system and document and include evidence of family notification; however, this does not always occur in a timely manner.	Four of twelve incident notifications were made between one and ten days after the event.	Ensure family are advised of adverse events in a timely manner.  90 days
Criterion 1.2.1.1 The purpose, values, scope, direction, and goals of the organisation are clearly identified	PA Low	A business and operational plan for the year is implemented in January each year. The documented plan documents goals and a range of action plans are developed for each goal. Responsibilities and timeframes are assigned. A plan for 2018 and 2019 were sighted.	The business plan for 2018 has not been reviewed.	Ensure business goals are reviewed quarterly and annually.

and regularly reviewed.				90 days
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	<p>PA</p> <p>Moderate</p>	<p>All staff meeting minutes were reviewed. Meeting minutes did not evidence discussion on trends of quality data or corrective actions. Data is displayed on the staff room noticeboard with numbers, types of incidents and trends. The new care centre manager reported that she plans to include discussion on clinical indicators at future staff and clinical meetings. Resident satisfaction surveys are completed, and the information received is collated and trended. There is no evidence of discussion or actions in response to the survey results.</p>	<p>(i) Satisfaction survey results are not acted on or shared with staff, residents or relatives.</p> <p>(ii) Quality data results that are being monitored, collated, trended and actioned at management level are not discussed at staff meetings.</p>	<p>(i) Ensure that the resident satisfaction results are reviewed, and results shared with staff, residents and families.</p> <p>(ii) Ensure trends in data and an analysis of data are shared with staff.</p> <p>90 days</p>
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA</p> <p>Moderate</p>	<p>Registered nurses are responsible for completing initial assessments and care plans within 24 hours of admission, however not all initial assessment and care plans were completed as required. Initial interRAI assessments are completed by RNs, however not all were completed within 21 days of admission. Long-term care plans were completed within 21 days of admission. InterRAI assessments have not been reviewed six monthly for six residents requiring review. Two of eight residents have been at the facility less than six months and do not require review. Timeframes were compromised partly as a result of a high turnover of registered nurses during 2018. There is a coordinated interRAI and care plan schedule in place for 2019.</p>	<p>(i) Two of eight resident files (one rest home and one hospital) did not have an initial interRAI completed within 21 days.</p> <p>(ii) Two of eight residents (one rest home and one hospital) did not have an initial care plan within the required timeframe. One of the</p>	<p>(i) and (ii) Ensure assessments and care plans are completed within the required timeframe.</p> <p>(iii) and (iv) Ensure interRAI reassessments and care plan evaluations are</p>

			<p>residents (rest home) did not have an initial assessment completed within the required timeframe.</p> <p>(iii) Long-term care plans for six residents (two rest home and four hospital) were not evaluated six monthly.</p> <p>(iv) Five (two rest home and three hospital) interRAI assessments had not been completed six monthly.</p>	<p>completed six monthly.</p> <p>90 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA</p> <p>Moderate</p>	<p>Long-term care plans were in place for all residents that identified the resident goals and objectives. Four of eight care plans had been updated to reflect the residents' current needs and interventions to safely guide care staff in the delivery of care.</p>	<p>(i) There were no documented interventions in place for two hospital residents with unintentional weight loss.</p> <p>(ii) There were no documented interventions for one hospital resident with constipation and haemorrhoids as per GP and progress notes.</p> <p>(iii) The long-term care plan had not been updated to reflect</p>	<p>Ensure that resident care plans include nursing interventions for identified needs.</p> <p>60 days</p>

			outcomes in the interRAI assessment for pain and behaviours.	
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Low	There are monitoring forms/charts in use that are completed as part of the caregiver and RN worklogs including food and fluid, weight, bowel charts, tuning charts, pain monitoring, restraint monitoring, blood pressure and neurological observations. Not all interventions around monitoring had been implemented as documented in the care plan and progress notes for one resident.	There are no documented interventions in place for one hospital level resident requiring hourly visual monitoring and behaviour monitoring chart as documented in the care plan and progress notes.	<p>Ensure all interventions are implemented as instructed.</p> <p>60 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.