Summerset Care Limited - Summerset on Summerhill

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 on Summerhill
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 31 October 2019 End date: 1 November 2019

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: 42

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

General overview of the audit

Summerset on Summerhill provides rest home and hospital (geriatric and medical) level care for up to 45 residents in the care centre. On the day of the audit, there were 42 residents.

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, staff and the nurse practitioner.

The service is managed by a non-clinical village manager who has experience in business management and human resources. She is supported by a care centre manager who has clinical management experience in aged care. Most recently, the service had appointed an experienced registered nurse (RN) to the clinical nurse leader position. The residents and relatives interviewed spoke positively about the care and services provided.

The service has addressed the one previous certification shortfall around care plan interventions.

This audit did not identify any areas requiring improvement by the service.

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.

Consumer interviews showed that they are well informed including of changes in resident's health. Management have an open-door policy. Advocacy services are available, and residents and family meetings take place as planned. Complaints and concerns have been managed and a complaints register is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.

The quality and risk management programme is implemented. Organisational performance is monitored through several processes to ensure it aligns with the identified values, scope and strategic direction.

There are human resources policies to support recruitment practices. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. An education and training programme for 2019 is implemented to the date of audit. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.

The sample of residents' records reviewed provided evidence that the service has implemented systems to assess, plan and evaluate care needs of the residents. The residents' care plans were comprehensive and included all required interventions and desired outcomes. Resident and/or family/whānau input is obtained in assessment stage and care plan development. The care plans are reviewed at least six monthly, or when there are changes in health status. Resident records included notes by the general practitioner, nurse practitioner, external specialists and allied health professionals.

Planned activities are appropriate to the group setting. The residents and family interviewed confirmed satisfaction with the activities programme. Food services were provided by an external contractor. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines, and additional requirements/modified needs were being met where required.

There is an appropriate medicine management system in place. Education and medicines competencies are completed by all staff responsible for administration of medicines.

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.

The building has a current warrant of fitness. A preventative and reactive maintenance plan is implemented. Progress towards the plan is recorded and this information is maintained electronically.

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 are in place to guide staff in the use of an approved enabler and/or restraint. On the day of audit, there were six residents assessed as requiring the use of restraint (bed rails only) and four requiring enablers (three bed rails and one lap belt. Staff training has been provided around restraint minimisation and management of challenging behaviours.

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.

Summerset on Summerhill has an infection control programme that complies with current best practice. The infection control programme is designed to link to the quality and risk management system. Records of all infections are kept and provided to head office for benchmarking. The service continued to implement their urinary tract infection prevention programme.

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	16	0	0	0	0	0
Criteria	0	41	0	0	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	There is an electronic complaint register. Verbal and written complaints are documented. The complaint register had two complaints which were related to the care centre. These two complaints reviewed had noted investigation, timeframes, corrective actions when required and were signed off as resolved. The results were fed back to the complainants and reported to staff. The complaint register was up to date. Complaint forms are available in the home and can be accessed by residents, family members and visitors. Residents and families interviewed knew how to raise concerns and were confident that any concerns would be listened and responded to. Staff interviews (five caregivers, three registered nurses, one chef, one recreational therapist and one maintenance staff) confirmed that residents were supported to express their views and were involved in decision making about their care. The 2019 Residents and Family Survey showed 90% satisfaction around communication about staff dealing with any concerns or issues raised by the residents and families.
Standard 1.1.9: Communication Service providers communicate effectively	FA	Families and residents are involved in the initial care planning, and ongoing feedback is provided. Five family members (four hospital and one rest home) and four residents (two hospital and two rest home) were interviewed. They all confirmed ongoing and timely communication. Resident's electronic notes showed that regular contact is maintained with family.

with consumers and provide an environment conducive to effective communication.		Fourteen incident and accident reports were reviewed. Nine of them had family notification immediately after an event, and three of those were non-resident related events so notification was not relevant. Resident/relative meetings are held three monthly. There are weekly advocacy services and two monthly newsletters to residents and families. The village manager and the care centre manager have an open-door policy, and residents and relatives interviewed confirmed this. Resident and relatives survey 2019 results showed 100% satisfaction around family notification after changes of care plan and any health concerns. Staff interviewed stated that they spoke to the care centre manager regularly to pass on information, ask questions and raise issues, which were addressed. If residents or family/whānau have difficulty with written or spoken English, the interpreter services are made available.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Summerset on the Summerhill currently provides care for up to 45 residents at hospital (geriatric and medical) and rest home level care in the care centre. On the day of audit, there were 42 residents which included 10 rest home residents and 32 hospital residents (including two residents on a health care recovery contract, one resident on respite care (hospital)). All 45 beds in the care centre are dual-purpose. All other residents were under the age-related residential care (ARRC) contract. The service also has two dedicated beds for people who are receiving radiotherapy, however there were no residents under this contract on both days of the audit. The Summerset Group Limited Board of Directors have overall financial and governance responsibility and there is a company strategic business plan in place. Summerset on Summerhill has a site-specific business plan 2019 and goals that are developed in consultation with the village manager, care centre manager and regional quality manager. There is a full evaluation at the end of the year. There is a retirement village attached as part of the complex with overall management of the site provided by the village manager. The village manager was on leave on both days of the audit. The village manager (non-clinical) and the care centre manager (RN) have been in the position for six years. A regional operations manager and regional quality manager are also available to support the facility and staff. Since the previous audit, a clinical nurse leader position was created, and an experienced RN with management experience was appointed to the position. He has been in his current role for about two months. The village manager and care centre manager have attended annual organisational forums and regional forums over two days. They both have attended at least eight hours of leadership professional development relevant to the role.
Standard 1.2.3: Quality	FA	Summerset on Summerhill is implementing the organisation's quality and risk management system. Policies

And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.		are reviewed on a regular basis from the head office. The content of policy and procedures are detailed to allow effective implementation by staff. Staff are required to read and sign for new/reviewed policies. The signed papers were evident in the staff training records. There are monthly accident/incident benchmarking reports completed by the care centre manager that breaks down the data collected across the rest home and hospital and staff incidents/accidents. Infection control is also included as part of benchmarking across the organisation. Summersets clinical and quality manager analyses data collected via the monthly reports, and corrective actions are required based on benchmarking outcomes. The regional quality manager is alerted automatically through their electronic system of any high-level accident/incidents (resident, staff and environmental). The internal audit programme is implemented. Issues arising from internal audits are developed into corrective action plans and re-audits as required. Monthly and annual analysis of results is completed and communicated to all staff. There is a meeting schedule including monthly quality improvement (all staff) meetings, registered nurse meetings and care staff meetings. The infection control coordinator provides a monthly report, and health and safety committee meetings are held. There are other facility meetings held, such as kitchen and activities. Quality data such as infections, accidents/incident, hazards, audit outcomes, concerns/complaints are discussed and documented in meeting minutes. Meeting minutes and quality data reports and graphs are available to all staff. The 2019 Annual Residents/Relatives Survey had 80% response rate. The survey reported 94.9 % overall satisfaction feedback of experience being either good or very good which showed 1.5% decline from the 2018 survey. This report had recently been circulated and the care centre manager stated that they will develop an action plan with staff once they identify areas for improvement. There is a health and safety and risk management programme in place including policies to guide practice that is generated from the national health and safety committee. Support is provided by the national health and safety manager who completes a comprehensive internal audit of the facility. The service has a health and safety representative (interviewed) with health and safety level 3 qualification. The health and safety committee meet monthly and review incidents/accidents/hazards and near misses. The committee provides a monthly report to management and the quality improvement meeting. Each month there is a focus on one of the golden rules of safety. All staff and contractors receive a health and safety induction. The hazard register has been updated. Summerset recently released, an addition to their human resource web page, the Leader Hub, to provide managers with additional tools to access information related to their role which included health and safety. The Health and Safety policy manual has been updated. Summerset had completed a health and safety survey in September and results of this survey will inform the 2020 Summerset National Health and Safety Plan. Staff receive regular updates and newsletters from the head office regarding national objectives and particularly around health and safety. 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. Pressure injury (PI) prevention also has a high priority among other quality improvement projects. Document review and discussions with RNs and caregivers confirmed that Summerset on Summerhill implements their PI prevention programme. Document review showed several examples of PIs on admission and PI healing records.
Standard 1.2.4: Adverse Event Reporting 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.	FA	Incident and accident data have been collected electronically and it is linked to service delivery plans and progress notes. Consequently, the data is analysed and benchmarked against other Summerset facilities. Fourteen incident and accident records (June – October 2019) reviewed included five falls, three PIs, two wandering incidences, minor burn from a bathroom tap, one medication error and two skin tears. Incident records identified timely RN assessment, corrective action and follow up. Neurological observations had been completed for unwitnessed falls. Corresponding progress notes reviewed documented incidents and interventions. Care plans reviewed included appropriate falls prevention interventions. Review of the minor burn case reviewed evidenced that appropriate clinical care had been provided following an incident including medical follow-up and replacement of water tap and maintenance check of the hot water system. All reports and corresponding resident notes reviewed evidenced that appropriate clinical care had been provided following an incident. 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. The local Public Health Authority was notified following an infectious outbreak.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	Human resources policies are implemented. A list of practicing certificates is maintained. Eight staff files (a recreational therapist, the clinical nurse leader, one cleaner, three caregivers and two RNs) were reviewed and all had relevant documentation relating to employment. Staff files were maintained electronically as well as paper-based. 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. Eight staff files had completed orientation documentation and one staff member was recently employed who was working towards completing her orientation. There is a staff member on duty at all times with a current first aid certificate. Staff are encouraged to complete Careerforce training. All staff have a minimum of level two training or are enrolled within three months of employment. An annual education programme was implemented and staff attendance records were maintained. Staff competency records were current. The service has five of ten RNs trained in interRAI, and

		one RN is currently undertaking interRAI training. Training records included good attendance numbers and sessions are repeated to capture staff who did not attend the training. RNs interviewed were happy with training and professional development support. A nurse practitioner visits the service on a weekly basis and provides support to the nursing team. Two senior RNs resigned earlier this year from their position, and a NETP and a newly graduated RN were employed in 2019. Staff interviews confirmed implementation of the training and orientation programme, and they stated that they are well supported to undertake their roles.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	A roster provides sufficient and appropriate coverage for the effective delivery of care and support. Discussions with the care centre manager confirmed that dual service bed capacity, and maximum number of rest home and hospital residents being determined by the Summerset Head Office, and roster adjustments were made accordingly. 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 leader works full time Tuesday to Saturday. There is an RN on duty 24/7, two RNs on morning and afternoon shifts and one RN at night. There are eight caregivers on the morning shift (four x eight hours, three x four hours and one x two and half hours), six on the afternoon shift (two in each wing including one eight hours and one six hours) and two on the night shift. The staffing roster reviewed showed that vacant shifts were covered. Caregivers interviewed confirmed that staff are replaced when off sick. There are three wings and two wings have a large number of hospital level care residents and staff allocation between wings reflects this. RNs and the care centre manager interviews confirmed that resident's acuity, level of dependency and staff's skills were considered for staff appointments. The service also employs two recreational therapists, two housekeepers, one laundry assistant, a property manager and administration team in addition to the care staff.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements	FA	The service uses an electronic charting and administration system and individualised robotic medication rolls. The system is accessed by use of individual passwords. Medications are administered by RNs, and there are also medicine competent caregivers to support RNs if needed. Twelve medication administration records sampled on the electronic system complied with current legislation, protocols and guidelines. Medications are stored in a safe and secure way in the locked drug trolley and locked medication room. Medication reconciliation is conducted by the RNs when the residents are transferred back to the service. All medications are reviewed every three months and as required by the GP or the nurse

and safe practice guidelines.		practitioner. Allergies were clearly indicated. The controlled drug register is current, and weekly checks by an RN and six-monthly stocktakes by the contracted pharmacist were completed. An annual medication competency is completed for all staff administering medications and medication training records were sighted. The medication round was observed during the audit and the medication process was noted to be correct and safe. Four residents were self-administering their inhalers at the time of the audit, and these residents were assessed as competent. Records were being maintained and medications were stored safely. There is a policy and procedure for self-administration of medication. Standing orders are not used. All medication records reviewed recorded indication for use of 'as required' medication by the GP or the nurse practitioner. There were five residents under anticoagulant therapy and three residents were insulin dependent. Two residents' medical records from each category were reviewed and no discrepancies were found. Medication is reviewed by an RN each time prior to administration, and pain assessments were undertaken before administering 'as required' analgesia.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	All meals at Summerset on Summerhill are prepared and cooked on site by an external catering company. There is a six-weekly seasonal menu which has been reviewed by a dietitian. The kitchen is adjacent to the dining room with meals served directly to residents from a bain marie in the kitchen. Resident likes/dislikes and preferences are known and accommodated with alternative meal options. Texture modified meals, fortified foods, protein drinks and diabetic desserts are provided. Staff were observed assisting residents with their meals and drinks in the dining rooms including recreational staff. The chef receives updates through the Summerset electronic patient management system and there is also a whiteboard with residents' special diets for a quick reference. Temperatures are monitored daily for the fridges, freezer and end-cooked foods. All foods were stored correctly and dated. A cleaning schedule is maintained. Food services were certified by MPI. All residents and family interviews confirmed satisfaction with food services. The 2019 Resident and Family survey reported 93% satisfaction with dining environment and 88% on size and quality of meals. Residents also have the opportunity to feedback on meals through direct feedback and resident meetings.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate	FA	Progress reports completed included achievements against the care plans. Specialist input was obtained as required. Two files included the recent hospital discharge, and review of the notes showed that required follow up including tests, the GP follow up and medication changes were completed by the nursing team. Six files reviewed had complex multiple health needs including high falls risk, current seizure episodes, pressure injury,

services in order to meet their assessed needs and desired outcomes.		palliative care, diabetes, one resident under the health recovery contract and a resident requiring anticoagulant therapy. All files had comprehensive care plan interventions that were reviewed regularly or with significant change. Therefore, the auditor considered that the required corrective action from the previous audit has been addressed. When a resident's condition changes, the RN initiates a review and if required, a GP or nurse specialist consultation. Relatives interviewed stated that their relative's needs are met, and they are kept informed of any health changes. There was documented evidence in the resident files of family notification of any changes to health including infections, accidents/incidents and medication changes. Residents interviewed stated that their needs are being met. Staff worked well together as a team, and there was excellent communication. Staff were made very aware of any recent changes to people's health and care needs when they came on duty through a staff handover meeting. This ensured that important information was shared and acted upon. Adequate dressing supplies were sighted. Initial wound assessments with ongoing wound evaluations and treatment plans were in place for five wounds, which include one skin ulcer, one skin lesions, two skin tears and one pressure injury stage 1. Evaluation comments were documented at each dressing change to monitor the healing progress. Photographs evidenced healing progress. Continence products are available and resident files included 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. There are a number of monitoring forms and charts available for use. RNs review the forms/charts and completed risk assessments for any changes to health status.
Standard 1.3.7: Planned Activities 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.	FA	Summerset on Summerhill employs two recreational therapists, one is studying towards obtaining a diversional therapy qualification. They both cover seven days a week and five hours a day between 10 am to 3.30 pm. There are two RTs on Wednesday and Thursday and one the RT works midday to 5.50 pm. There is a full range of social activities that are available on the weekly programme for all residents to participate in. The activities are used to support physical and emotional wellbeing. One-on-one contact is made daily with residents who are unable to or choose not to participate in group activities. Summerset on Summerhill continues to implement their cognitive stimulation therapy for residents and there are two facility owned pets to facilitate this programme. Ladies and men's group continue to meet weekly to participate in activities and outings of interest to the group. There are twice weekly outings in the facility van that accommodates a wheelchair. External organisations and individuals are welcomed to the service to maintain community connections. There are number of external

		entertainers noted on the activities programme. Festive occasions and events are celebrated. A daily exercise programme and Tai Chi is offered to residents. All the activities evidenced documented evaluations on the residents' participation. Residents' records reviewed had a documented activity plan that reflects their preferred activities of choice. The residents were observed participating in a variety of activities on both days of the audit. Residents were also observed going out with family members or NOK. The residents and relatives interviewed reported overall satisfaction with the level and variety of activities provided. The 2019 Resident and Relatives survey reported 95% satisfaction around easy to access and participation in activities, and 92% were happy with the range of activities offered and 82% satisfied scheduling and frequency of activities.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Initial care plans, interRAI assessments, short-term care and long-term care plans were evaluated/reviewed in a comprehensive and timely manner. Reviews were fully documented and included current resident's status, any changes and achievements towards goals. Family/whānau, residents and staff input is obtained in all aspects of care. Short-term needs care plans are developed for acute needs. There is evidence of multidisciplinary team involvement in the reviews including input from the GP, nurse practitioner, care staff, RT and any allied health professionals involved in the resident's care. Activities plans are reviewed as part of the residents' care plan reviews. The GP and nurse practitioner complete three-monthly medical reviews.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building has a current warrant of fitness. There is a full-time property manager who actions repairs and maintenance requests through the electronic maintenance system. Monthly planned maintenance is completed as per the planned maintenance schedule and includes monthly hot water temperatures, internal and external building maintenance and clinical equipment checks (trolleys, walking frames and wheelchairs). There are essential contractors available 24 hours.
Standard 3.5: Surveillance Surveillance for infection	FA	The infection control surveillance programme is implemented. Infection events are collected and analysed monthly. The infection events, trends and analysis are reviewed by management and data is forwarded to head office for benchmarking. This information is then communicated to all staff through clinical and staff meetings.

is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.		Infection control audits are completed, and corrective actions are signed off. There was a norovirus outbreak in 2019. Thirteen staff members, twenty-four residents and four students were affected. Discussion with the infection control officer and the care centre manager, and document review confirmed that the outbreak was well managed and the local DHB and the public health authorities were notified. Consequently, additional staff training around infection control and prevention were provided to staff. Areas for improvement were identified and corrective actions were developed and followed up. The service continued to implement a UTI reduction programme including the hydration programme, however benchmarking data shows higher infection rates than previous years.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	There are policies around restraints and enablers. The service currently has six residents assessed as requiring the use of restraint (bed rails only) and four requiring enablers (three bed rails and one lap belt). Residents voluntarily request and consent to enabler use. Staff receive regular education and training on restraint minimisation. Staff interviewed were knowledgeable around restraint minimisation and enablers. Review of two residents with restraint and one resident with an enabler showed that ongoing monitoring of restraint and enablers occurs, and risk assessments and care plan reviews were completed by an RN. Ongoing consultation with the resident and family/whānau is also identified in the resident records.

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.

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.