

# Summerset Care Limited - Summerset at Karaka

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## 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:

<b>Legal entity:</b>	Summerset Care Limited
<b>Premises audited:</b>	Summerset at Karaka
<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: 23 January 2020      End date: 23 January 2020
<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

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## Introduction

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

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

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

### Key to the indicators

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

Indicator	Description	Definition
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 at Karaka provides rest home and hospital (geriatric and medical) level care for up to 50 residents in the care centre and up to 20 rest home residents in the serviced apartments. On the day of the audit, there were 56 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 was orientating to the role on the day of the audit. He is supported by a care centre manager who has clinical management experience in aged care. They are supported by two experienced clinical nurse leads. The residents and relatives interviewed spoke positively about the care and services provided.

The service has addressed the one previous certification shortfall around implementation of the quality programme.

This audit identified two areas requiring improvement by the service around neurological observations and medication management.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Resident and relative 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.		Some standards applicable to this service partially attained and of low risk.
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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. The education and training programme for 2019 has been implemented, and the 2020 programme has commenced. 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.		Some standards applicable to this service partially attained and of low risk.
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Registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family input. Care plans viewed demonstrated service integration and are reviewed at least six monthly. Resident files include medical notes by the contracted general practitioners and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and senior medication competent caregivers are responsible for the administration of medicines. Medication charts are reviewed three monthly by the GP.

The recreational therapists implement the activity programme to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations.

All meals are cooked on site. Residents' food preferences, dislikes and dietary needs are recorded. The food control plan has been verified.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building holds a temporary warrant of fitness which will be confirmed when the changeover of fire service providers is completed. Systems and supplies are in place for essential, emergency and security services.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Restraint minimisation and safe practice policies and procedures are in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit, the service had no residents using restraint and one resident with an enabler.

## 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.
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Summerset at Karaka continue to implement their infection surveillance programme. Infection control issues are discussed at both the infection control and quality, and staff meetings. The infection control programme is linked with the quality 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)
<b>Standards</b>	0	14	0	2	0	0	0
<b>Criteria</b>	0	40	0	2	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)
<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 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>A complaints procedure is provided to residents within the information pack at entry. The village manager and the care centre manager have overall responsibility for ensuring all complaints (verbal or written) are fully documented and investigated. On occasions, complaints are escalated to the head office for assistance (sighted). Feedback forms are available for residents/relatives in various places around the facility.</p> <p>An electronic complaint's register that included relevant information regarding the complaint. Documentation included follow-up letters and resolution were available. The number of complaints received each month is reported monthly to staff via the various meetings. There were 18 complaints received in 2019 and none received YTD for 2020. Follow-up letters and resolutions were completed within the required timeframes. One recent complaint was received via the DHB, the complaint was fully investigated, and a corrective action plan was developed with progress reporting documented to ensure all aspects of the complaint have been addressed. All actions have been addressed, and the complaint has been closed. Staff interviewed five registered nurses (RNs) two clinical leads, two caregivers one kitchen manager, two recreational therapists, and one maintenance could describe directing all complaints and concerns to the most senior person on duty.</p>
<p>Standard 1.1.9: Communication</p>	FA	<p>The village manager and the care centre manager have an open-door policy. Six residents (three hospital and three rest home) and three relatives (hospital) stated they were welcomed on entry and were given time and explanation about services and procedures. Relatives interviewed also stated they are informed of changes in the health status</p>



<p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>of residents and incidents/accidents. Ten electronic incident reports reviewed (five hospital and five rest home) evidenced relatives were notified following incidents.</p> <p>Resident/relative meetings are held monthly. If residents or family/whānau have difficulty with written or spoken English, the interpreter services are made available.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Summerset at Karaka provides rest home and hospital (geriatric and medical) level care for up to 50 residents in the care centre and rest home level care across 20 certified serviced apartments. On the day of the audit, there were a total of 56 residents. Fifty residents in the care centre, (including five rest home level residents and 45 hospital residents, including one resident on an orthopaedic interim care contract and two residents on respite). There were six residents in the serviced apartments receiving rest home care.</p> <p>The Summerset Group Limited Board of Directors have overall financial and governance responsibility and there is a company strategic business plan in place.</p> <p>Summerset at Karaka has a site-specific business plan and goals that is developed in consultation with the village manager, care centre manager and regional operations manager (ROM). The quality plan is reviewed regularly throughout the year. There is a full evaluation at the end of the year. The 2019 evaluation was sighted.</p> <p>The village manager has been in the current role for less than a week (at the time of the audit), he was being orientated by a relief manager who has been employed with Summerset for two and a half years and has previous experience as a regional manager for another provider. The care centre manager (registered nurse) has been in his role for eight months, he has previous clinical manager experience, and has a previous background in physiotherapy. They are supported by an experienced regional quality manager (present on the day of the audit), who has previous experience as a care centre manager and village manager. She is a registered nurse with a background in teaching. The village manager and care centre manager are supported by two experienced clinical nurse leads (CNLs) who have experience in age care.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and</p>	<p>FA</p>	<p>Summerset at Karaka has a documented quality and risk management system. The Summerset group has a Summerset 'Quality Assurance and Training Calendar for 2020'. The calendar schedules the training and audit requirements for the month and the care centre manager is responsible for confirming completion as required to head office. The calendar includes (but is not limited to); monthly quality improvement such as internal audits, training sessions and meeting schedules. Summerset Karaka meetings have occurred as scheduled in the planner. The Summerset internal audit schedule programme includes all aspects of clinical care, environmental, organisational and human resource management. The service has been implementing the internal audits as</p>

<p>maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>scheduled. Corrective actions arising from internal audits are developed into corrective action plans. Monthly and annual analysis of results is completed and provided across the organisation. The previous finding around meetings and internal audits has been addressed.</p> <p>There are monthly accident/incident benchmarking reports completed by the care centre manager that break down the data collected via VCare across the rest home and hospital and staff incidents/accidents. Infection control is also included as part of benchmarking across the organisation. Health and safety internal audits are completed. Summerset's clinical and regional quality manager analyses data collected via the monthly reports and corrective actions are required based on benchmarking outcomes.</p> <p>Satisfaction surveys are completed annually. There was not much differences in the responses between 2018 and 2019. Overall satisfaction was 97.2%. Areas of high satisfaction were residents felt respected, 82% felt the dining experience met expectations, 86% felt concerns or issues were dealt with effectively, and 98% felt staff accommodate personal choices and preferences. Areas of lower satisfaction had corrective actions in place. The results had been discussed at the monthly staff meetings and weekly management meetings.</p> <p>There is a health and safety and risk management programme in place including policies to guide practice. The maintenance manager is the health and safety representative (interviewed). The service addresses health and safety by recording hazards and near misses into a designated electronic database, sharing of health and safety information and actively encouraging staff input and feedback. The service ensures that all new staff and any contractors are inducted to the health and safety programme. 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>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</p>	<p>PA Low</p>	<p>Incident and accident data has been collected and analysed. Ten resident related incident reports for January 2020 were reviewed (five hospital and five rest home including a resident from the serviced apartments). All reports and corresponding resident files reviewed evidenced appropriate registered nurse follow-up following an incident.</p> <p>Relatives have been notified on occasions and the forms were fully completed with detailed progress notes documented, however not all neurological observations were completed as policy following unwitnessed falls. Data is linked to the organisation's benchmarking programme and used for comparative purposes. Discussions with the service confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Section 31s were sighted for two resident behaviours and a sudden death. The regional quality manager reported section 31 notifications were sent for changes in management (not sighted).</p> <p>Outbreaks in April and in May 2019 were well managed with timely notifications and correspondence kept on file.</p>

manner.		
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are policies and procedures in place to guide management on employment processes. A list of practising certificates is maintained. Six staff files (one clinical nurse lead, two RNs, two caregivers and one diversional therapist) 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.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The role-specific 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.</p> <p>There is an annual education plan that is outlined on the 'quality assurance calendar'. All compulsory education sessions and competencies have been held over a two year period and are included in the 2020 planner. All education sessions have occurred as scheduled and a record of completion is maintained on staff files.</p> <p>Care staff are encouraged to complete Careerforce training. Currently there are thirteen caregivers with level 2, eight caregivers with level 3 and six caregivers with level 4 NZQA qualifications.</p> <p>Registered nurses have current first aid certificates and have access to external training sessions. There are four RNs including one CNL who are interRAI trained with another two enrolled.</p> <p>The care centre manager has attended the palliative care conference and has completed a continuous leadership course. The clinical nurse leaders attend monthly CNL meetings which includes mentoring and coaching with the managers and regional operations manager.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>A staffing levels and skills mix policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery.</p> <p>The village manager and care centre manager work 40 hours per week Monday to Friday and are available on call at all times for any emergency issues or clinical support. There are two clinical nurse leads who work full time. One clinical nurse lead works Sunday to Thursday, and one works Tuesday to Saturday.</p> <p>In the care centre, there are two RNs on duty across all shifts. They are supported by eight caregivers on morning shifts; 5x 7 am to 3 pm, 2x 7 am to 1 pm and 1x 8 am to 12 midday. Seven caregivers are rostered for the afternoon shift; 4x 3 pm to 11 pm, 2x 4 pm to 11 pm and 1x 4 pm to 9 pm. One caregiver works nightshift with the two RNs.</p> <p>The RN on duty provides oversight to the rest home residents in the serviced apartments. There are two caregivers on duty in the serviced apartments on a morning shift (1x 7.30 am to 12 midday, and 1x 7 am to 3 pm). Afternoon shift has one caregiver from 3 pm to 11 pm. The caregiver in the care centre assists anyone that requires help</p>

		<p>overnight.</p> <p>If there is a resident from the village requiring assistance overnight, the caregiver would attend in the first instance with the first aid bag and radio, to report back to the RNs in the care centre for advice if required. An RN would attend if required.</p> <p>Staff carry pagers that alert them to call bells, and two-way radios so they can communicate effectively. Interviews with residents and relatives confirmed that staffing levels are sufficient to meet the needs of residents. A staff availability list ensures that staff sickness and vacant shifts are covered. Caregivers interviewed confirmed that staff are replaced when off sick.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	PA Low	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There was one resident self-administering on the day of audit. A consent form had been signed and the resident deemed competent to self-administer. The medication roll is in the resident's locker. The resident refuses to lock this. The resident never leaves the room and there are currently no residents who wander. There are no standing orders. There are no vaccines stored on site.</p> <p>The facility uses an electronic and robotic pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. RNs and senior medication competent caregivers administer all medications. Staff attend annual education and have an annual medication competency completed. All but two new RNs are syringe driver trained by the hospice. The medication fridge temperature is checked weekly and the service has commenced documenting daily room temperatures. Eye drops are dated once opened.</p> <p>Staff sign for the administration of medications on the electronic system. Ten medication charts were reviewed (five rest home and five hospital). Medications are reviewed at least three monthly by the GP. There was photo ID and allergy status recorded. 'As required' medications had indications for use charted.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service</p>	FA	<p>The service has a head chef who works Monday-Friday 40 hours a week. There are three other chefs who all work 40 hours a week and overlap each other. All cooks have current food safety certificates. The head chef oversees the procurement of the food and management of the kitchen. There is a well equipped kitchen and all meals are cooked on site. Meals are served in each area from hot boxes. The temperature of the food is checked before serving. Special equipment such as lipped plates is available. On the day of audit meals were observed to be hot and well presented. Kitchen staff were in the dining room checking with residents regarding meals. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures were monitored and recorded weekly. Food temperatures are checked, and these were all within safe limits. The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. Changes to residents'</p>

<p>delivery.</p>		<p>dietary needs have been communicated to the kitchen. Special diets and likes and dislikes were noted. One gluten free resident had initial problems with dietary requirements, but the kitchen has worked with the resident and these have now been overcome. The four weekly menu cycle is approved by a dietitian. The residents can ask for alternatives. All resident/families interviewed were satisfied with the meals.</p> <p>The food control plan expires 7 February 2021.</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>FA</p>	<p>When a resident's condition changes the RN initiates a GP consultation. Staff stated that they notify family members about any changes in their relative's health status. Care plans sampled had interventions documented to meet the needs of the residents and there is documented evidence of care plans being updated as residents' needs changed.</p> <p>Resident falls are reported on electronic accident/incident forms and written in the progress notes. Neurological observations are taken when there is a head knock or for an unwitnessed fall, but are not always completed as per policy (link 1.2.4.5).</p> <p>Care staff interviewed stated there are adequate clinical supplies and equipment provided including continence and wound care supplies.</p> <p>Electronic wound assessment, wound management and wound evaluation forms are in place for all wounds. Wound monitoring occurs as planned. There is a wound register stating what day wounds are due and when completed. One chronic wound has been seen by the wound nurse specialist and there are photos of the wounds progress. There is currently one facility acquired stage two pressure injury. This has been seen by the wound care nurse specialist and there are photos of the wounds progress. The right heel is kept elevated off the bed.</p> <p>Monitoring forms are in use as applicable, such as weight, vital signs and wounds. Behaviour charts are available for any residents that exhibit challenging behaviours. Caregivers document changes of position on a turning chart.</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,</p>	<p>FA</p>	<p>There are two recreational therapists who both work thirty hours a week. Both are currently completing a diversional therapy course. Both work across all areas.</p> <p>There is a weekly programme in large print on noticeboards in all areas. Every Monday, each resident is given a copy of the weekly programme to keep in their room. Residents have the choice of a variety of activities in which to participate and every effort is made to ensure activities are meaningful and tailored to residents' needs. These include exercises, walking groups, craft, cooking classes, bingo, news from the paper and movies.</p> <p>Those residents who prefer to stay in their room or who need individual attention have one on one visits to check if there is anything they need and to have a chat.</p>

<p>and the setting of the service.</p>		<p>There is an interdenominational church service and Catholic communion weekly.</p> <p>There are twice weekly van outings. Both drivers have first aid certificates.</p> <p>Special events like birthdays, Chinese New Year, Easter, Mothers' Day, Anzac Day and Melbourne Cup are celebrated.</p> <p>There is a weekly visit from a dog and it's owner. An entertainer visits every Friday.</p> <p>There is community input from local preschools and choirs. Residents go out shopping and to cafés. Some residents participate in AUTs music therapy group.</p> <p>Residents have an activity assessment completed over the first few weeks following admission that describes the residents past hobbies and present interests, career and family. Resident files reviewed identified that the comprehensive individual activity plan is based on this assessment. Activity plans are evaluated at least six monthly at the same time as the review of the long term care plan.</p> <p>Resident meetings are held monthly.</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>Except for the respite resident and interim care resident, all plans reviewed had been evaluated by the registered nurse six monthly or when changes to care occurred. Short- term care plans for short-term needs are evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. Activities plans are in place for each of the residents and these are also evaluated six monthly. The multidisciplinary review involves the RN, GP and resident/family if they wish to attend. There is at least a three monthly review by the GP. The relatives interviewed confirmed that they are informed of any changes to the care plan.</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 facility is currently in the process of changing their fire service providers. Meanwhile the building holds a temporary warrant of fitness (expiring 8 October 2020) which will be confirmed once the changeover of fire services is completed. There is a preventative and reactive maintenance programme. Hot water temperatures have been monitored randomly in resident areas and were within the acceptable range. The sound of the call bells is turned down low in the evenings to prevent disturbing residents.</p>
<p>Standard 3.5:</p>	<p>FA</p>	<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. The infection control</p>

<p>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>		<p>coordinator (clinical nurse lead) provides infection control data, trends and relevant information to the infection control committee and clinical/quality meetings.</p> <p>Infection events are entered into VCare and extracted monthly into share point electronic system. Areas for improvement are identified and corrective actions are developed and followed up. The facility is benchmarked against other Somerset facilities of similar size and benchmarking results are fed back to the infection control coordinator and used to identify areas for improvement. Infection control audits are completed, and corrective actions are signed off (sighted). Surveillance results are used to identify infection control activities and education needs within the facility. There was a scabies outbreak in April 2019, which was well managed, and documented. Public Health was notified. The gastro outbreak in May 2019 was also well managed and documented. Public Health was notified appropriately.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>There are policies around restraints and enablers. One of the clinical nurse leads is the restraint coordinator. Restraint and enabler logs are maintained.</p> <p>There were no residents requiring the use of a restraint and one resident using a bedrail as an enabler at the time of audit. An assessment, consent and electronic care plan were in place. Four hourly monitoring was maintained as documented in the care plan. Staff receive training around restraint minimisation that includes annual competency assessments.</p> <p>The caregivers interviewed could clearly describe the difference between a restraint and an enabler.</p>

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	PA Low	All incident reports reviewed were fully completed and showed RN follow-up and relatives' notifications. Where possible opportunities to minimise risks were documented, or existing interventions were reviewed.	Three of four unwitnessed falls did not have neuro observations completed as per policy.	<p>Ensure neurological observations are completed as per the policy or discontinued following a documented clinical assessment.</p> <p>180 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal,</p>	PA Low	The facility uses an electronic and robotic pack system. The medication fridge temperature is checked weekly and the service has commenced documenting daily room temperatures. There is a controlled drug register. Weekly stocktakes are not	(Weekly stocktakes are not being completed consistently as per policy and the controlled drug register is not documented as per policy (medications	Ensure weekly stocktakes are completed consistently as per policy and ensure the controlled drug



and medicine reconciliation in order to comply with legislation, protocols, and guidelines.		being completed consistently as per policy.	dosage missing from top of page).	register is documented as per policy.  60 days
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display
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End of the report.