

Summerset Care Limited - Summerset by the Park

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Summerset Care Limited
Premises audited:	Summerset by the Park
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 11 December 2020 End date: 11 December 2020
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:	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. The residents and relatives interviewed spoke positively about the care and support provided.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Service 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 care centre manager is appropriately qualified and experienced and is supported by a village manager and two clinical nurse leaders.

Five of six previous shortfalls in relation to communication of adverse events, business plan reviews, the quality and risk management system, timeframes, and care plan interventions have been addressed by the service. One shortfall remains around monitoring.

This surveillance audit identified four further partial attainments in relation to staff orientation, the provision of physiotherapy services, the activities programme assessments and plans and the monitoring of hot water temperatures.

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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Discussions with residents and relatives confirmed that residents and (where appropriate) their families are involved in care decisions. Regular contact is maintained with families including if a resident is involved in an incident or has a change in their current health.

Complaints processes are being implemented in accordance with the Health and Disability Commissioner (HDC) guidelines.

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.
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Summerset by the Park has implemented a quality and risk management system. Key components of the quality management system are reported monthly to head office. Annual surveys and quarterly resident meetings provide residents and families with an opportunity for feedback about the service. Quality performance data for incidents, infections and internal audit results are collated monthly.

Human resources policies cover recruitment, selection, orientation and staff training and development. The orientation programme provides new staff with 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>
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There is an admission package available prior to or on entry to the service. 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.

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

The diversional therapist implements 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 requirements are identified at admission and accommodated. Residents commented positively on the meals. Snacks are available at all times.

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.		Some standards applicable to this service partially attained and of low risk.
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The building has a current warrant of fitness. Resident rooms and bathroom facilities are spacious. A reactive maintenance programme is being implemented. The outdoor areas are safe and easily accessible and provide seating and shade.

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 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 eight residents requiring the use of a restraint and three residents using an enabler at the time of the 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 and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator is responsible for the collation of infections and orientation and education for staff. There is a suite of infection control policies and guidelines to support practice. Information obtained through surveillance is used to determine infection control activities and education needs within the facility. There have been no outbreaks since the previous audit.

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	13	0	2	2	0	0
Criteria	0	38	0	3	2	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The organisation has a complaints policy that describes the management of the complaints process. Complaints forms and booklets are available from reception, describing the complaints process. 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>An electronic complaint register is in place. Verbal and written complaints are documented. Twenty-five complaints have been lodged in the register for 2020 (year to date). Three complaints relating to resident cares were selected for review. All three complaints reflected evidence of acknowledgment, an investigation, and resolution with timeframes, as determined by the health and disability commissioner (HDC) met. Corrective actions were implemented where indicated. Results are fed back to complainants and are reported to staff (evidenced in meeting minutes).</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with</p>	FA	<p>Interviews with six residents (four hospital and two rest home including a rest home level resident in a serviced apartment) and two (hospital level) family members confirmed they were welcomed on entry and were given time and explanation about services and procedures. Family members interviewed stated they are informed of changes in the health status of residents and incidents/accidents. This was evidenced in all ten incident/accident forms reviewed. This is an improvement from the previous audit.</p>

<p>consumers and provide an environment conducive to effective communication.</p>		<p>The service has policies and procedures available for access to interpreter services. 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 by the Park is certified to provide rest home and hospital (geriatric and medical) levels of care. There are 56 dual purpose beds and 55 apartments certified as being able to be used for residents requiring rest home level of care. The organisation has limited the number of certified serviced apartments to 27. Summerset by the Park holds medical certification for their hospital residents.</p> <p>On the day of the audit, there were 14 residents requiring rest home level care and 42 requiring hospital level care. One of the residents requiring rest home level of care was residing in a serviced apartment and three rest home level residents in the care facility were on a respite contract. The remaining residents were on the age-related residential care contract (ARRC).</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 2020 operations business plan includes goals, business requirements and benefits and measures of success. The quality plan is documented in January each year, with evidence of quarterly reviews. This is an improvement from the previous audit.</p> <p>The village manager has been in the current role at Summerset by the Park since January 2020. He previously was a registered nurse (RN) and has worked for the Summerset organisation for two years. The village manager is supported by an experienced care manager/RN. The care manager has been in the position since August 2019 and has many years of experienced as an RN, including aged care experience. He was unavailable during this spot surveillance audit. The care manager is supported by two clinical nurse leads.</p> <p>Village managers and care managers attend annual organisational forums and regional forums. They have maintained over eight hours of professional development relevant to their roles.</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 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>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 manager. Results are shared with head office and graphs are</p>

<p>maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>placed on the staffroom noticeboard. The internal audit programme includes monthly audits which have been completed as planned (evidenced for the 2020 calendar year). Corrective actions, where opportunities for improvements are identified, have been completed as required. Quality results are discussed in staff and residents' meetings. This is an improvement from the previous audit. Interviews with three caregivers, four RNs (two clinical nurse leaders, one RN and one EN), one maintenance staff, one recreation officer and one chef indicated their involvement in quality and risk activities.</p> <p>The 2019 resident survey reflected an improvement in satisfaction levels to 89% and the recently completed 2020 survey indicated 93.3% of residents are satisfied with the services they are receiving. The village manager is currently in the process of developing corrective actions in response to the 2020 survey.</p> <p>There is a health and safety and risk management programme in place including policies to guide practice. The village manager is the health and safety officer and is supported by a health and safety committee of eight individuals.</p> <p>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 manner.</p>	<p>FA</p>	<p>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 is used for comparative purposes.</p> <p>Ten resident related incident reports (September – November 2020) were reviewed (seven falls [four with completed neurological observations post fall], two skin tears, one pressure injury). All reports and corresponding resident files reviewed evidenced that appropriate clinical care has been provided following an incident.</p> <p>Discussions with the village manager and quality regional manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Section 31 notifications since the last audit have been made for pressure injuries and notifications to police.</p>
<p>Standard 1.2.7: Human Resource Management</p>	<p>PA Moderate</p>	<p>There are human resources policies to support recruitment practices. A list of practising certificates is maintained although the (foreign trained) physiotherapist does not hold a New Zealand practising certificate.</p> <p>Six staff files were selected randomly for review (two RNs, three caregivers, one diversional therapist). Sighted was</p>

<p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>evidence of interviews, reference checking, police vetting and signed employment agreements and job descriptions. Performance appraisals are 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 orientation programme includes documented competencies and induction checklists. Evidence of staff completing their orientation programme was sighted in only two of six staff files. The village manager stated that all staff have been orientated but some staff had not yet submitted their completed orientation paperwork. 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 being implemented. The service is trialling the delivery of mandatory education topics within blocks of scheduled times. Staff are rostered to attend. Core competencies are completed, and a record of completion is maintained on staff files and on an electronic human resources database.</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>	<p>FA</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>The village manager and care manager work 40 hours per week Monday to Friday and are available on call for any emergency issues or clinical support.</p> <p>The care centre is located on the third level of the facility. During this spot surveillance audit, there were 55 residents in the care facility (13 rest home and 42 hospital level) and one rest home level resident in a serviced apartment on the third level.</p> <p>Two clinical nurse leads/RNs work full time (ten hour/day staggered shifts that include Saturday/Sunday cover). In addition, there are two RNs (or one RN and one EN) on the AM and PM shifts and one RN on the night shift.</p> <p>There are ten caregivers on the morning shift (seven long shifts and three short shifts), nine on the afternoon shift (five long and four short) and two on night shift.</p> <p>The RN on duty provides oversight to the one rest home resident in a serviced apartment. One caregiver is on duty to provide cover for the serviced apartments on the AM and PM shifts. The night shift is staffed with a designated caregiver working in the care centre. All staff carry pagers.</p> <p>Interviews with residents and relatives confirmed that staffing levels are sufficient to meet the needs of residents.</p>
<p>Standard 1.3.12: Medicine</p>	<p>FA</p>	<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</p>

<p>Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>and the resident deemed competent to self-administer. The nasal spray was in a drawer. 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 administer all medications. Staff attend annual education and have an annual medication competency completed. All RNs are syringe driver trained by the hospice. The medication fridge temperature is checked weekly. Eye drops are dated once opened.</p> <p>Staff sign for the administration of medications on the electronic system. Ten medication charts were reviewed (six hospital and four rest home). 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 delivery.</p>	FA	<p>The service has three cooks who cover Monday to Sunday and seven part-time kitchen assistants. All cooks have current food safety certificates. The head cook 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. 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' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes were noted. The four weekly menu cycle is approved by a dietitian. The residents choose from three options. All resident/families interviewed were satisfied with the meals.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans are resident-centred. Interventions documented support needs and provide detail to guide care. This is an improvement from the previous audit. Short-term care plans are in use for changes in health status. Residents and relatives interviewed stated that they were involved in the care planning process. There was evidence of service integration with documented input from a range of specialist care professionals including the hospice nurse, wound care nurse and mental health care team for older people. The care staff interviewed advised that the care plans were easy to follow.</p>
<p>Standard 1.3.6: Service</p>	PA	<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. All care plans sampled had interventions documented</p>

<p>Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>Moderate</p>	<p>to meet the needs of the resident and there is documented evidence of care plans being updated as residents' needs changed. Missing was evidence of monitoring being documented as completed. This previous shortfall remains an area for improvement.</p> <p>Resident falls are reported on accident forms and written in the progress notes. Neurological observations are taken when there is a head injury or for an unwitnessed fall.</p> <p>Care staff interviewed stated that 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 are currently 24 wounds being treated. There are currently three stage one pressure injuries. One is non-facility acquired. Pressure injury prevention equipment is available and in use.</p> <p>Electronic 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.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>PA Low</p>	<p>There is a diversional therapist who works 35 hours a week and a recreational officer who works 28 hours a week. Both work across all areas. On the day of audit residents were observed listening to a newspaper reading, playing word games, having fun with armchair travel and enjoying a visiting choir.</p> <p>There is a monthly programme in large print in each resident's room and a weekly programme in large print on all noticeboards. 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.</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 or to have a chat.</p> <p>There is an interdenominational church service every Sunday and a Catholic service every Wednesday.</p> <p>There are van outings twice weekly. Special events like birthdays, Easter, Mother's Day, Anzac Day, and the Melbourne Cup are celebrated. Recently the facility held a residents' ball which was reported by residents as greatly enjoyed. Happy hour is every Friday and there is entertainment at this every second week. On the alternate weeks there is karaoke.</p> <p>The facility has fish and a canary. They are currently negotiating a return to pet therapy which had ceased during Covid-19.</p> <p>There is community input from local pre-schools and junior colleges as well as choirs and dance groups. Residents go out shopping, to cafés for coffees, on picnics and for ice-creams.</p>

		<p>Residents are scheduled to 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 individual activity plan is based on this assessment. Activity plans are scheduled to be evaluated at least six-monthly at the same time as the review of the long-term care plan. Activity assessments and plans were missing in a sample of the residents' files reviewed.</p> <p>Resident meetings are held three-monthly.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Except for the new admission, all long-term care 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. 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 family members 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>	PA Low	<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 2021.</p> <p>A full-time property manager of the care centre and villas oversees a team of property assistants and one groundsman. Maintenance requests are generated through the on-line system and closed off when completed or on a paper-based system. 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 were reported in an interview with the property manager as being checked monthly, although this is not being recorded. 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 3.5: Surveillance</p> <p>Surveillance for</p>	FA	<p>Policies and procedures document infection prevention and control surveillance methods. The surveillance data is collected and analysed monthly to identify areas for improvement or corrective action requirements. Infection control internal audits have been completed. Infection rates have generally been low. Trends are identified, and quality initiatives are discussed at staff and quality meetings. There is a policy describing surveillance methodology</p>

<p>infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>for monitoring of infections. Definitions of infections are in place appropriate to the complexity of service provided. Systems are in place that are appropriate to the size and complexity of the facility.</p> <p>During Covid-19 there has been continuing education around personal protective equipment (PPE) with emphasis on donning and doffing of gowns and gloves. There has also been continuing education on hand hygiene, what to do for an outbreak and staff wellness. There is Covid information on both staff and resident noticeboards. The IC coordinator emails any new information on Covid-19 to the RNs. There is a designated isolation room. During lockdown, residents were kept in their respective wings and staff were assigned to the same areas. The pandemic plan has been updated to include Covid-19 and head office has a Covid-19 response folder available.</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. At the time of the audit, there were eight hospital level residents requiring the use of a restraint (bedrails and one fall out chair) and three hospital level residents using an enabler (bedrails). Staff receive training around restraint minimisation that includes annual competency assessments.</p> <p>One file reviewed of a resident using an enabler indicated that an assessment has been completed and signed consent had been given by the resident. This enabler is being reviewed monthly.</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 1.2.7.2 Professional qualifications are validated, including evidence of registration and scope of practice for service providers.	PA Low	Annual practising certificates were sighted for the registered nursing staff and external health professionals (eg, GP, pharmacy, podiatry, dietitian). The physiotherapist who regularly visits the facility, completes initial assessments and designs treatment programmes for residents, is a foreign trained physiotherapist who does not hold a current practising certificate. The head physiotherapist who employs this individual stated that he oversees her work. There was no documented evidence to indicate that she was being supervised.	The foreign-trained physiotherapist who is contracted to provide physiotherapy services twice per week (eight hours) does not hold an annual practising certificate.	Ensure there is documented evidence (eg, co-signing all assessments, treatment plans and progress notes) to indicate that the physiotherapist who is working at Summerset by the Park is being supervised by a physiotherapist with a current practising certificate. 90 days
Criterion 1.2.7.4 New service providers receive an orientation/induction programme that	PA Moderate	An orientation programme is in place for staff. In addition to completing a workbook, caregivers are buddied with more experienced staff before working independently. The caregivers and RNs interviewed reported that the orientation programme was comprehensive and provided them with	Documented evidence of staff completing an orientation programme were missing in four of six	Ensure staff files contain evidence of staff completing their orientation programme.

covers the essential components of the service provided.		sufficient information. Four of six staff files reviewed (three caregivers and one RN) did not include documented evidence to indicate that they had completed their orientation programme.	staff files.	90 days
Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Moderate	Interventions are documented in the care plans according to resident's assessed needs and goals. Interventions are not always implemented as instructed.	One care plan stated that the resident was to have hourly visual checks. There was no documented evidence of this occurring.	Ensure hourly visual checks are documented. 60 days
Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	PA Low	Activity assessments are to be completed on admission and re-evaluated six monthly or as required. Preferences of residents are sought and inform the development of planned activities.	i) Two of five activity assessments had not been completed in a timely manner. ii) Two of five files reviewed did not evidence a completed activity plan.	Ensure all activities assessments and plans are completed within timeframes. 90 days
Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.	PA Low	A preventative maintenance programme is being implemented with the exception of the monthly hot water monitoring of residents' taps, which isn't being recorded.	The property manager interviewed stated that the property assistant responsible for	Ensure there is documented evidence to indicate that water temperatures for residents' water taps are being monitored regularly.

			monitoring residents' hot water taps is completing them but is not documenting the results of the findings.	90 days
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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.