

Summerset Care Limited - Summerset At Bishopscourt

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 at Bishopscourt
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 21 February 2022 End date: 21 February 2022
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
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 Bishopscourt provides rest home and hospital level care for up to 42 residents in the care centre and up to 20 rest home residents in serviced apartments. On the day of the audit there were 40 residents in the care centre and two rest home residents in the serviced apartments. The residents and relatives interviewed spoke positively about the care and support provided.

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

The service is managed by a non-clinical village manager who has been in the role since 2013, and a care centre manager (RN) who has been in the role since January 2021. The management team is supported by a regional operations manager and regional quality manager, one experienced clinical nurse lead, a team of registered nurses and caregivers.

One area for improvement was identified around resolution of incidents and accidents.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Residents and families are kept informed. Residents and their family/whānau are provided with information on the complaints process on admission. Complaints are being managed in a timely manner. Staff are aware of the complaints process and to whom they should direct complaints.

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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Services are planned, coordinated, and are appropriate to the needs of the residents. A village manager and care centre manager/registered nurse are responsible for the day-to-day operations of the facility. Quality and risk management processes are maintained, reflecting the principals of continuous quality improvement. Quality goals are documented for the service. Corrective action plans are implemented where opportunities for improvement are identified. A risk management programme is in place, which includes a risk management plan, incident and accident reporting, and health and safety processes. Adverse, unplanned, and untoward events are documented by staff.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice, meeting legislative requirements. An orientation programme is in place for new staff. Ongoing education and training for staff is in place.

Registered nursing cover is provided 24 hours a day, seven days a week. There are adequate numbers of staff on duty to ensure residents are safe.

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.
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Residents are assessed prior to entry to the service and a baseline assessment is completed upon admission. The registered nurses are responsible for each stage of provision of care including assessments, care plans and evaluations. Risk assessment tools and monitoring forms are available and implemented. Residents and relatives interviewed confirmed that they were happy with the care provided and the communication.

Planned activities are appropriate to the resident's assessed needs and abilities and residents advised satisfaction with the integrated activities programme. There are outings into the community and visiting entertainers when Covid restrictions allow.

There is a secure electronic medication system at the facility. There are medicine management policies that align with acceptable guidelines. Staff responsible for the administration of medications complete annual medication competencies and education. The general practitioner reviews the medication charts three monthly.

Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on site. The kitchen is well equipped for the size of the service. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.

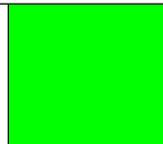


Standards applicable to this service fully attained.

A current building warrant of fitness is posted in a visible location (expiry 5 May 2022). There is a preventative and planned maintenance schedule in place.

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.

Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. At the time of the audit, the service had four residents assessed as requiring the use of bedrails as restraint and no enablers.

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 officer uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This included audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Summerset facilities. Covid-19 plans are in place and PPE is available.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	15	0	1	0	0	0
Criteria	0	40	0	1	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
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission. Interviews with four residents (two rest home and two hospital) and family members confirmed their understanding of the complaints process. Eleven staff interviewed (three caregivers, two registered nurses (RNs), one diversional therapist, three kitchen staff, one cleaner, one property manager) were able to describe the process around reporting complaints.</p> <p>There is an electronic complaint register that includes verbal and written complaints and evidence to confirm that complaints are being managed in a timely manner including acknowledgement, investigation, timelines, corrective actions (when required) and resolutions. Four complaints were received in 2021 and all are resolved. One complaint has been received in 2022 and is currently open while the care centre manager is completing an investigation.</p> <p>One complaint was lodged with the Health and Disability Commissioner in 2020 in regards to resident cares and has been closed following the implementation of recommendations including: adoption of the ISBAR communication tool which has been adopted by Summerset facilities nationally; updates to the hydration policy (sighted) that was released nationally; all care staff were required to read this policy; staff training in regards to hydration assessments and fluid balance (sighted); training for staff on 'the unwell patient' (sighted); evidence of the implementation of observations charts (sighted). In addition, the wound policy was updated to include haematomas and haematoma has recently been added as a wound type to the Summerset wound assessments.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>An open disclosure policy describes ways that information is provided to residents and families. The admission pack provides residents and families with a comprehensive range of information regarding the scope of service provided to the resident and any items they are to pay for that are not covered by the agreement. Regular contact is maintained with family including if an incident or care/health issues arises. Five family members interviewed (four hospital, one rest home) stated they were well-informed. Twenty incident/accident forms were reviewed, and all identified that the next of kin were contacted.</p> <p>There are monthly resident's meetings chaired by the diversional therapist where issues or concerns to residents are able to be discussed. Minutes are maintained and show follow-up actions for resolution of matters raised.</p> <p>The service can access interpreter services through the DHB. This has not been required.</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 Bishopscourt provides rest home and hospital level care for up to 42 residents in the care centre. In addition, there are 20 beds in the ground floor serviced apartments certified for rest home level of care. The rooms in the care centre are dual-purpose; approved for both rest home and hospital level of care. On the day of the audit there were 42 residents - 9 rest home level, 31 hospital level and 2 rest home level residents in the serviced apartments. All residents were on the age-related residential care agreement (ARRC).</p> <p>The 2021 business plan reflected evidence of quarterly reviews. The 2022 business plan with measurable goals is now in place.</p> <p>The village manager has been employed by Summerset for a number of years and was not on site during the audit due to current roster structure to manage Covid-19 precautions and team bubbles. The village manager was available via phone. There is a care centre manager who is a registered nurse (RN) and has been employed at Summerset at Bishopscourt for 13 months. Prior to this role, this person worked for the DHB for 18 months and in other aged care facilities in management roles (e.g. clinical nurse advisor and care home manager) for four years. She is assisted by a clinical nurse leader/RN (CNL) who has been at the facility for two years.</p> <p>The village manager and care centre manager have maintained greater than eight hours of professional development activities related to managing an aged care facility.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established,</p>	<p>FA</p>	<p>A quality and risk management plan is in place. Policies and procedures reflect evidence of regular reviews as per the document control schedule. New and/or revised policies are made available for staff to read and sign that they have read and understand the changes. Village managers and care centre managers are held accountable for their implementation.</p> <p>The monthly collating of quality and risk data includes (but is not limited to) residents' falls, infection rates, and pressure areas. Data is collated and benchmarked against other Summerset facilities to identify trends. A resident</p>

<p>documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>satisfaction survey is conducted each year. Results for 2021 reflected a 97.4% satisfaction rate (sample of 39 residents/families). No corrective actions were required. An annual internal audit schedule was sighted for the service. Corrective actions are developed where opportunities for improvements are identified and are signed off by a manager when completed. Staff are kept informed of audit findings and quality initiatives via meeting minutes. Minutes are posted in the staffroom if staff are unable to attend the meetings. A quality initiative that was underway at the time of the audit was investigating polypharmacy and its relationship to residents' falls.</p> <p>A falls reduction plan was sighted for the service. Falls prevention strategies are in place that include the identification of interventions on a case-by-case basis to minimise future falls. Sensor mats and physiotherapy services are utilised.</p> <p>There is a health and safety team who meet monthly. Meeting minutes are posted in the staffroom. Adverse event data relating to health and safety is entered electronically. Each month a health and safety 'golden rule' is posted in a visible location to alert staff. Hazard identification forms and a hazard register are in place. The hazard register is updated annually (at a minimum). New staff and contractors are orientated to health and safety processes which continue annually.</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>PA Low</p>	<p>The service collects a comprehensive set of data relating to adverse, unplanned, and untoward events. This includes the collection of incident and accident (events) information. The reporting system is integrated into the quality and risk management programme. A sample of 20 adverse events were reviewed (witnessed and unwitnessed falls, challenging behaviours). All 20 events sampled (December 2021 – January 2022) evidenced clinical follow-up immediately following the event. Neurological observations are conducted for all unwitnessed falls and/or suspected injury to the head. The care centre manager stated that she discusses adverse events with the clinical nurse leader on a weekly basis but is behind in documenting corrective actions taken to prevent their reoccurrence and sign-off. This is an area identified for improvement.</p> <p>Discussions with the care centre manager confirmed her awareness of statutory requirements in relation to essential notification. Section 31 reports have been completed for stage three or unstageable pressure injuries. There was one outbreak reported to Public Health authorities in November 2021. The DHB was informed of the HDC complaint (2020).</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource</p>	<p>FA</p>	<p>There are job descriptions available for all relevant positions that describe staff roles, responsibilities, and accountabilities. The practising certificates of health professionals are current (e.g. RNs, GP, pharmacist, and physiotherapist).</p> <p>Five staff files were reviewed (three caregivers, one RN, one clinical nurse leader). Evidence of signed employment</p>

<p>management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>contracts, job descriptions, reference checks, police vetting, and completed orientation specific to the job role were sighted. Performance appraisals for staff have been conducted 12 weeks post-orientation and annually thereafter.</p> <p>The service has a training policy and schedule for in-service education. The in-service schedule is implemented, and attendance is recorded. Corrective actions implemented to address low attendance rates include offering sessions multiple times and offering staff online learning. There are implemented competencies for registered nurses including (but not limited to), medication, restraint, syringe driver and insulin administration.</p> <p>There are nine RNs employed, which includes the care centre manager and clinical nurse lead. Eight of the nine RNs have completed their interRAI. Thirty-three caregivers are employed; four have completed their level four Careerforce qualification, six their level three qualification and six their level two qualification. There are two international RNs employed as caregivers.</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>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. The care centre manager is employed Monday – Friday and the clinical nurse lead works Tuesday – Saturday.</p> <p>There were forty residents in the care centre (nine rest home level and thirty-one hospital level).</p> <p>Two RNs or one RN and one EN are rostered on the AM and PM shifts and one RN is rostered for the night shift, seven days a week</p> <p>On the AM shift, there are seven caregivers (four working a long [eight hour] shift and three working shorter duties [0700 – 1330 (1) and 0800 – 1300 (2)]). On the PM shift there are five caregivers (two long and three working shorter duties (1500 – 2130, 1700 – 2100, 1700 – 2200)). Two caregivers are on duty at night.</p> <p>There were two rest home level residents in the serviced apartments. One caregiver is rostered 24/7.</p> <p>A recent change to the roster is the introduction of a kaitiaki (lounge carer who is also available for specialing residents). This position was vacant at the time of the audit. Families interviewed advised that they felt there was sufficient staffing, remarking that the staff are very busy. The roster is changed in response to resident acuity and occupancy.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner</p>	<p>FA</p>	<p>There are medicine management policies and procedures that align with recognised standards and guidelines for safe medicine management practice. The service has an electronic resident file which includes the electronic medication system. All hospital and rest home residents including those in the care serviced apartments are entered onto the electronic medication system. All medications were stored securely in the locked medication room. The medication room had adequate safe storage and was at the correct temperature – less than 25 degrees Celsius. The medication fridges were monitored weekly. Original labels were present on medication in the medication trolley</p>

<p>that complies with current legislative requirements and safe practice guidelines.</p>		<p>and cupboards. Medications such as eyedrops and creams are dated on opening.</p> <p>Medication is administered by RNs and senior caregivers, and annual competencies are completed by staff who administer medications. When interviewed RNs and caregivers understood their medication administration role. The RNs, enrolled nurse and senior caregivers are responsible for the administration of medications and have completed medication competencies and annual medication education. The RNs have completed syringe driver training. All medications and robotic rolls were evidenced to be checked on delivery with any discrepancies fed back to the supplying pharmacy. Standing orders are not used. Controlled drug medications are stored securely, and the register was reviewed as accurate, with required checks having been conducted.</p> <p>All ten (six hospital, two rest home and two rest home from the serviced apartments) electronic medication charts reviewed were charted and signed by the GP. Each of the charts were reviewed three monthly, photo identification and allergies were documented. All 'as required' PRN medications had indications for use identified and were correctly prescribed and administered as directed.</p> <p>There were no residents self-medicating.</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>	<p>FA</p>	<p>The food control plan is current and expires in March 2022. The kitchen has a qualified chef who has worked in the service since it opened, kitchenhands support these roles. All staff have appropriate training and food handling qualifications.</p> <p>Residents have a nutritional assessment which forms the basis of the long-term care plan. Residents are encouraged to express their likes and dislikes and this information is provided to the kitchen. There is a whiteboard where individual requirements are recorded so the information is accessible for all staff. Special diets and individual requirements are catered for in the kitchen.</p> <p>The menu is planned by a dietitian over four 12-week rotations. The dietitian is available for residents' assessments as required.</p> <p>The kitchen is spacious and clean, and all the food was stored appropriately off the floor and dated correctly. There is food safety information available on a noticeboard, the food control plan and kitchen manual, with relevant policies and procedures available in the kitchen. Fridge and food temperature monitoring occurs as required.</p> <p>Food temperatures are checked when the food leaves the kitchen and when it is served. Food is transported to the care centre to be served. Due to Covid-19 restrictions, the chef does not currently serve residents in the care centre. Rather, all meals are sent up to the care centre to be served by care staff from bain-maries directly to the residents who are dining in the dining room or plated and trayed and delivered to residents in their rooms.</p> <p>Chemicals were appropriately labelled and stored with emergency management information available.</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>Electronic care plans are updated by the RN in response to a change in a resident's health status/condition, a three-monthly review or other review by GP, NP, or other health professional. Registered nurses interviewed could describe how they access specialist support for continence and wound management when necessary. The sample of care plans confirmed the residents supports and needs are being met.</p> <p>The electronic resident file provides assessment, records progress, and also has the management plan for wounds and the evaluations of wounds. Monitoring forms are utilised with residents who have identified needs in these areas, these include (but are not limited to) pain, food, fluid, restraint, vital signs, monthly weighs.</p> <p>There is a wound summary folder where information regarding each wound is kept, enabling the CNL and RNs to have a better overview of the total number and frequency of dressings required each day. There were nine residents with ten wounds including five venous ulcers, one skin tear, one abrasion, one bruise, and two post excision wounds. One resident had dry scaly skin and one resident had incontinence associated dermatitis that the staff were monitoring and recording progress. Pressure relieving equipment was in place for residents who have been identified as at risk of developing a pressure injury. There were no pressure injuries on the day of audit.</p> <p>There are adequate supplies available for wound care and continence with specialist advice from the SDHB specialist staff as required.</p> <p>Residents and family/whānau interviewed were satisfied their needs are being satisfactorily met.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>There are two permanently employed activities staff. Both are diversional therapists, and each staff member has a current first aid certificate.</p> <p>These staff each work four shifts over seven days and provide a programme for both rest home and hospital residents. There is also a van driver available. There is a monthly planner which provides information regarding available activities which include (but are not limited to) movement to music, themed craft activities, and newspaper reading which provides opportunity for reminisce. The programme is flexible when spontaneous events of interest occur within the confines of Covid-19 restrictions.</p> <p>There is a van with a wheelchair space. Residents are encouraged to maintain previous interests and community links. If they are no longer able to independently do this the staff will work hard to assist this to occur with examples given. In an effort to maintain safety and prevent contraction and spread of Covid-19, the service has split the facility into the two wings. Each wing has turnabout at dining at the dining room tables and attending activities each day. Other activities occur in resident's rooms. When Covid restrictions ease, the service will resume the normal activities programme. Rest home residents in the serviced apartments attend activities with other retirement village residents. There are dedicated care staff in the serviced apartment ground floor area.</p> <p>Residents and families interviewed expressed satisfaction with the activities provided and the staff involved.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The initial and long-term care plans sampled evidenced evaluations within appropriate timeframes; 21 days for the initial and six monthly or earlier depending on the resident for long term. The short-term care plans reviewed had also been evaluated by the RN.</p> <p>Family/whānau and resident input is evident in the care plans with them having opportunity to attend or provide input into the six-monthly MDT meeting. The utilisation of the MDT approach is demonstrated in the evaluation of care plans with feedback from GPs, physiotherapist, and NP.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The full-time maintenance person is on-call outside of business hours. This role supervises the property and gardening staff and receives works orders from Summerset's head office which provide the annual routine maintenance plan. The routine maintenance plan has monthly schedules which include (but not limited to) testing and tagging of equipment, equipment checks and calibration of equipment (kitchen and medical equipment), windows, and boiler checks. Hot water temperatures have been tested and recorded monthly with readings maintained less than 45 degrees Celsius. Reactive maintenance requests are sent in response to any issues that arise. There are preferred contractors who are available 24/7.</p> <p>There is adequate equipment available for staff to provide for the residents' needs.</p> <p>There are three levels; serviced apartments on the ground floor – these are all certified for rest home care, care centre on the first floor and independent apartments on the second level. The building is spacious, with corridors wide enough for residents/visitors to easily pass. The external areas are well maintained with safe access to all communal areas and outdoor areas. The outdoor balcony has seating and shade.</p> <p>The building warrant of fitness expires on 5 May 2022.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection</p>	FA	<p>The infection control policy includes a surveillance procedure, process for detection of infection, infections under surveillance, outbreaks and quality and risk management. Infection events are collected monthly and entered into the electronic system. The infection control officer provides infection control data, trends and relevant information to the infection control committee and clinical/quality meetings. Areas for improvement are identified, corrective actions developed and followed up. The facility is benchmarked against other Summerset facilities of similar size and benchmarking results are fed back to the infection control officer and used to identify areas for improvement. Infection control audits across all services are completed and corrective actions are signed off (sighted). Surveillance results are used to identify infection control activities and education needs within the facility. Reports and graphs are displayed on the staffroom infection control noticeboard. Infection prevention is part of orientation of new staff including hand hygiene, use of personal protective equipment (PPE) and standard and transmission-</p>

control programme.		<p>based precautions. The service had a Norovirus outbreak in November 2021 with 16 residents and seven staff affected. The service notified Public Health and the DHB of this outbreak and it was well contained within two weeks.</p> <p>The service has clearly defined Pandemic plans for Covid-19 alert levels and has procured sufficient supplies of PPE. Visiting restrictions are in place due to Omicron outbreak in the community. Hand sanitisers were appropriately placed throughout the facility. Covid isolation kits have been put together in readiness, and education and training for staff has been provided. All visitors must register at reception and be screened. Covid vaccinations have been provided for staff and residents. The service maintains a large supply of outbreak management resources, which includes but is not limited to special bins with lids, antibacterial wipes, clothing protectors, gowns, surgical masks, N95 masks, gloves, specific bags for contaminated items, antibacterial gels, and sprays.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There are policies to guide the use of restraints and enablers. The service currently has four (hospital level) residents assessed as requiring the use of restraint (bed rails) and no residents requiring an enabler. Their care plans are up to date and provide the basis of factual information in assessing the risks of safety and the need for restraint. Ongoing consultation with the resident and family/whānau is also identified.</p> <p>Staff received training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers.</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	<p>Accidents and incidents are documented electronically on the vCare system. An RN investigates the adverse event at the time of its occurrence. The care centre manager stated that she meets weekly with the clinical nurse leader to discuss adverse events but has gotten behind schedule in regard to documenting corrective actions and signing them off.</p>	<p>Documented evidence of corrective actions and sign-off were missing in 15 of 20 accident/incidents reviewed over the December 2021 - January 2022 period.</p>	<p>Ensure all adverse events are reviewed with corrective actions implemented to prevent their reoccurrence; and are signed off as resolved by the care centre manager (or clinical nurse leader).</p> <p>90 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.