

# Summerset Care Limited - Summerset By the Sea

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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:

**Legal entity:** Summerset Care Limited

**Premises audited:** Summerset By the Sea

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 18 January 2018      End date: 18 January 2018

**Proposed changes to current services (if any):**

**Total beds occupied across all premises included in the audit on the first day of the audit:** 40

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

## General overview of the audit

Summerset by the Sea is part of the Summerset Group and provides rest home and hospital (medical and geriatric) level care for up to 69 residents. On the day of audit, there were 40 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, interviews with residents, family, management, staff and a general practitioner.

The village manager and care centre manager are appropriately qualified and experienced. Feedback from the residents and families was positive about the care and services provided.

The service has addressed all nine shortfalls from their previous certification (five shortfalls) and partial provisional (four shortfalls) audits around residents' privacy, communicating quality results to staff, corrective action plans, kitchen management (two shortfalls), completion of construction projects, fire drill training in the new wing, completing landscaping for the new wing, and restraint evaluations.

This certification audit identified that three improvements are required in relation to staff orientation, residents' interventions 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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The residents' privacy is respected. Communication takes place in an open manner. Complaints processes are implemented, and complaints and concerns are managed appropriately.

## 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 appropriate to the needs of the residents. A care centre manager is responsible for the day-to-day operations of the care facility. Quality and risk management processes are established. Strategic plans and quality goals are documented for the service. A risk management programme is in place, which includes a risk management plan, incident and accident reporting, and health and safety processes. Staff document adverse, unplanned and untoward events. The health and safety programme meets current legislative requirements. A staff education and training programme is embedded into practice. Registered nursing cover is provided twenty-four 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.		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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The registered nurses are responsible for each stage of provision of care including assessments, care plans and evaluations within the required timeframes. Risk assessment tools and monitoring forms were available and implemented. Resident care plans were individualised with evidence of resident/family involvement. Allied health professionals and the general practitioner are involved in the care of the residents.

A diversional therapist and recreational therapist coordinate and implement an integrated activity programme that meet the individual recreational needs and preferences. There are outings into the community and visiting entertainers.

There are medicine management policies in place that meets legislative requirements. Staff responsible for the administration of medications complete annual medication competencies and education. The general practitioner reviews the medication charts three monthly.

The food service is contracted to an external company. Resident's individual dietary needs were identified and accommodated. Staff have attended food safety and hygiene training.

## Safe and appropriate environment

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

Standards applicable to this service fully attained.

There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. The building holds a current warrant of fitness. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. Systems 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.

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.

## Infection prevention and control

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

Standards applicable to this service fully attained.

The infection control programme is appropriate for the size and complexity of the service. The infection control officer (registered nurse) is responsible for collating infections by type and frequency and analysing for trends or areas of improvement. The infection control officer uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. Information is fed back through meetings and graphs displayed. This includes outcomes of audits of the facility and surveillance of infection control events and infections. The service engages in benchmarking with other Somerset facilities.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	16	0	2	1	0	0
Criteria	0	39	0	4	0	0	0

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



# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld.	FA	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms for lodging informal complaints (feedback) and formal complaints are readily available.</p> <p>Information about the complaints process is provided on admission. Interviews with residents and family confirmed their understanding of the complaints process. Six staff interviewed (two RNs, two caregivers, one diversional therapist, one chef) were also able to describe the process around reporting complaints.</p> <p>An electronic complaints register is maintained. Evidence was sighted to confirm that complaints are being managed in a timely manner including acknowledgement, and investigation. All lodged complaints were documented as resolved. One complaint that was lodged with the Health and Disability Commissioner (HDC) in 2015 has recently been signed off by HDC with no further actions required.</p> <p>The complaints process is linked to the quality and risk management system. Complaints received are communicated to staff, evidenced in the various staff meeting minutes.</p>
Standard 1.1.3: Independence, Personal Privacy,	FA	Residents' personal belongings are used to decorate their rooms. All rooms are single occupancy in the care facility, with a selection of rooms with full ensuites. Privacy signage was evident on all communal toilet and shower doors. A curtain separates the shower from the toilet area. These are improvements from the previous certification

<p>Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>		<p>audit.</p> <p>The two caregivers interviewed reported that they knock on bedroom doors prior to entering rooms, ensure doors are closed when cares are being given and do not hold personal discussions in public areas. They reported that they promote the residents' independence by encouraging them to be as active as possible. All five residents interviewed (three hospital and two rest home) and one relative interviewed (hospital) confirmed that residents' privacy is respected.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>An open disclosure policy describes ways that information is provided to residents and families. The admission pack includes a comprehensive range of information regarding the scope of services provided to the resident on entry to the service, and any items they have to pay for that is not covered by the agreement. Regular contact is maintained with families including when an incident or care/health issues arises. This was evidenced in all 10 accident/incident forms that were randomly selected for review. An interview with a relative confirmed that they are kept informed.</p> <p>A formal agreement is in place with an external provider for interpreter and translation services. The information pack is available in large print and can be read to residents. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so.</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>	FA	<p>Summerset by the Sea provides rest home and hospital level care for up to 49 residents. In addition, 20 serviced apartments are certified for rest home level of care. On the day of the audit, there were 40 residents in the care facility (14 at rest home level and 26 at hospital level). This included one palliative care (hospital), one young person with a disability (hospital level), and three residents on respite (one hospital, two rest home). The remaining residents were on the aged residential care contract. All residents' rooms in the care facility have been approved for dual-purpose. There were no rest home level residents in the serviced apartments.</p> <p>A village manager is responsible for the retirement village and a care centre manager/RN is responsible for operations in the care facility and serviced apartments. The village manager was employed in November 2016. Previous to this role, he was an engineer. The care centre manager has nine years of experience as a nurse manager in the aged care sector and was employed at another Summerset facility before beginning her employment at Summerset by the Sea in August 2015. She was on leave during the audit. A clinical nurse leader, the village manager and the care centre staff assisted the auditors in her absence.</p> <p>The organisation is guided by a philosophy, vision and values. A 2017 operations business plan, specific to Summerset by the Sea, lists measurable goals and objectives. Business goals are regularly reviewed and are currently in the process of being updated.</p>

		The village manager and the nurse manager have attended a minimum of eight hours professional development activities per annum related to managing an aged care facility.
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>The quality and risk management programme is established through the head office. 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, then sign that they have read and understand the changes. The village manager and care centre manager are held accountable for their implementation.</p> <p>The monthly collection of quality and risk data includes (but is not limited to) residents' falls, infection rates, skin tears and pressure injuries. A resident satisfaction survey is conducted annually. An internal audit schedule is being implemented with audits completed as per the schedule. Meeting minutes evidenced that quality data and results are being communicated to staff. This is an improvement from the previous certification audit.</p> <p>Corrective actions are developed and implemented where opportunities for improvements were identified. They are signed off by management following implementation. This is an improvement from the previous certification audit.</p> <p>Falls prevention strategies are being implemented. This includes the implementation of interventions on a case-by-case basis to minimise future falls.</p> <p>The health and safety programme meets current legislative requirements. A contractor induction programme is in place. Hazard identification forms and a hazard register are being implemented. Reporting is electronic, and includes senior management input for high-risk events. Links are in place to ensure the board is kept informed of any high-risk events.</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>	FA	<p>Adverse events are recorded on accident/incident forms which are input into an electronic format. An RN reviews each adverse event and responded appropriately in ten adverse events reviewed. If hazards are identified, these are reported to the health and safety team for evaluation. The care centre manager or clinical nurse lead signs off each adverse event following the RNs investigation. Neurological observations are conducted for unwitnessed falls where there is a suspected injury to the head.</p> <p>The service collects data relating to adverse, unplanned and untoward events, which are linked to the quality and risk management system.</p> <p>Discussions with the village manager and one RN (clinical nurse lead) confirmed their awareness of statutory requirements in relation to essential notification with examples provided.</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>	PA Low	<p>Job descriptions are in place for all relevant positions that describe staff roles, responsibilities and accountabilities. The practising certificates of health professionals were current. Five staff files were reviewed (three caregivers, two RNs). Evidence of signed employment contracts, job descriptions, reference checking and police vetting were sighted. Staff reported that they all completed an orientation programme but evidence of completed programmes were missing in three of the five files reviewed for staff hired within the first six months of the 2017 calendar year. Annual performance appraisals for staff are regularly conducted.</p> <p>The service has a training policy and schedule for in-service education. The in-service schedule is implemented, and attendance is recorded. Staff receive a minimum of eight hours of education per year. A system for determining staff competency is implemented. The competencies for RNs includes (but is not limited to) medication, syringe driver and insulin administration.</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>The service has a documented rationale for determining staffing levels and skill mix for safe service delivery. Registered nurses are rostered on-site 24 hours a day, seven days a week. The care centre manager/RN is supported by a clinical nurse lead/RN, staff RNs and two enrolled nurses. One staff RN and one EN are scheduled on the am shift, seven days a week. They are supported by six caregivers (five long shifts and one short shift). The pm shift is staffed with one RN and six caregivers (five long and one short) and the night staff is staffed with one RN and three caregivers. There were no rest home level residents living in the serviced apartments at the time of the audit. The village manager reported that a staffing plan is in place to adjust for the care of rest home level residents in serviced apartments.</p> <p>The village manager reported that there have been two recent changes to staffing levels to assist in accommodating the increased resident census. Caregivers no longer are responsible for laundry duties (effective May 2017) and caregivers are no longer responsible for providing meals/tea for residents (effective August 2017). Agency staff is used to cover absences that are unable to be filled by Summerset staff. Caregiver staff respond to call-outs in the retirement village. Only one caregiver is assigned to conduct an assessment of the situation and if additional assistance is required, an ambulance is contacted.</p> <p>Interviews with residents and one relative confirmed that they felt there was sufficient staffing. During the audit, a robust activities programme was being implemented throughout the day.</p>
<p>Standard 1.3.12: Medicine Management</p>	PA Moderate	<p>There are medicine management policies and procedures that align with recognised standards and guidelines for safe medicine management practice in accordance with the Medicines Care Guide for Residential Aged Care 2011. The RNs, enrolled nurse and senior caregivers are responsible for the administration of medications and have</p>

Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.		<p>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. There were three self-medicating residents (one hospital and two rest home) with a self-medication competency, however, two of the residents did not have their competencies regularly reviewed.</p> <p>All medications were stored correctly. The medication fridge temperature is monitored weekly.</p> <p>Ten resident medication charts (six hospital and three rest home) were reviewed on the electronic medication system. Staff recorded the time, date and effectiveness of 'as required' medications. All 'as required' medications had an indication for use. Oxygen therapy had not been prescribed.</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>Medirest is contracted for the provision of meals on-site and to the village café. The food service team complete on-line food safety training. Staff were observed wearing correct personal protective clothing including hair nets while in the kitchen. These are improvements from the previous audits (certification and partial provisional). There is an eight-week rotating four seasonal menu approved by the organisational dietitian. Resident likes/dislikes and preferences are known and accommodated with alternative meal options including a vegetarian option. Texture modified meals, protein drinks diabetic desserts and gluten free meals are provided. The chef receives a dietary profile for each resident. The chef (interviewed) is notified of any changes to residents' dietary requirements and resident preferences. Specialised crockery and utensils are provided as required. Plated meals are transported in hot boxes to the dining areas.</p> <p>All fridge and freezer temperatures throughout the facility are monitored and recorded daily. This is an improvement from the previous audits (certification and partial provisional). End-cooked food temperatures are recorded on all meats and menu foods. All foods are stored correctly, and date labelled. Cleaning schedules are maintained. Chemicals are stored safely within the kitchen.</p> <p>Feedback on the meals is provided through direct feedback, resident meetings and surveys.</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</p>	PA Low	<p>When a resident's condition changes, the RN initiates a review and if required a GP or nurse specialist consultation. One relative interviewed stated their relative's needs are met and they are kept informed of any health changes. There was documented evidence in the resident files of family notification of any changes to health including infections, accidents/incidents, and medication changes. Residents interviewed stated their needs are being met. Short-term care plans are used for short-term needs and were sighted for wounds, skin tear and skin infection, however, not all short-term health changes and interventions had been documented.</p> <p>Adequate dressing supplies were sighted. Initial wound assessments with ongoing wound evaluations and treatment plans were in place for residents with wounds, however, there were no documented interventions in place for pressure injuries. Wounds are re-assessed at least monthly. Evaluation comments and photos monitor the</p>

desired outcomes.		<p>healing progress. The CNL confirmed there was a wound nurse specialist available as required. One hospital medical resident was admitted with four pressure injuries (stage one of the right heel and side of left foot and two stage three pressure injuries of the left heel and sacrum).</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed.</p> <p>Monitoring forms are available to monitor resident health and progress against implemented interventions. There was a shortfall around weights on admission. There were no documented interventions for three residents with identified pain.</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>	FA	<p>The service employs a recreational therapist who has commenced diversional therapist (DT) training. She is employed for 30 hours a week. She is supported by a recreational assistant for 10 hours per week. The activity team attend Summerset training sessions and the lead DT for Summerset oversees the activities plan a month in advance. The programme is implemented Monday to Sunday and flexible to meet the resident needs and preferences.</p> <p>The integrated rest home/hospital programme includes activities of interest or suggestions made by residents. Activities meet the recreational needs of the residents ensuring all residents have the opportunity to attend activities such as exercises, newspaper reading, arts and crafts, board games, quizzes and technology and Google groups. One-on-one time is spent with residents who choose to stay in rooms or unable to participate in group activities. There are regular weekly trips for outings, shopping, and attending community groups/functions including concerts and events. Community visitors include entertainers, village volunteers, guest speakers, school children and pet therapy. Rest home residents in serviced apartments are invited and assisted to attend the care centre activity programme. The younger person activities reflect their individual interests and hobbies including quiz nights and using the internet. Residents are encouraged to maintain their former community links. Church services are held.</p> <p>Resident meetings provide an opportunity for residents to feedback on the programme. The recreational therapists are involved in the multidisciplinary review which includes the review of the activities.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and</p>	FA	<p>There is evidence of resident and family involvement in the evaluation of resident care plans. Initial care plans were evaluated by the registered nurses within three weeks of admission. Written evaluations had been completed six monthly or earlier for resident health changes. There is evidence of multidisciplinary (MDT) team involvement in the reviews including input from the GP, care staff and any allied health professionals involved in the resident's care. Families are invited to attend the MDT review and asked for input if they are unable to attend. Short-term care plans sighted have been evaluated by the RN. The GP completes three monthly reviews or more frequently</p>

timely manner.		for residents with more complex problems.
<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 building has a current building warrant of fitness posted in a visible location (expiry 18 April 2018). This is an improvement from the previous (partial provisional) audit.</p> <p>All construction work for the new wing has been completed including the installation of ceiling tiles in the bridge connecting the first-floor care beds to the existing care centre and rails have been installed in the new showers. These are improvements from the previous (partial provisional) audit.</p> <p>The facility has wide corridors with sufficient space for residents to safely mobilise using mobility aids. Residents have access to outdoor areas. This is an improvement from the previous (partial provisional) audit. Seating and shade is provided.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>Emergency and disaster policies and procedures, and a civil defence plan for the service, are documented. Fire drills are conducted six monthly. This is an improvement from the previous (partial provisional) audit. The orientation programme and annual education and training programme includes fire and security training (link 1.2.7.4). Staff interviewed confirmed their understanding of emergency procedures. Required fire equipment was sighted on the day of audit. Fire equipment has been checked within required timeframes.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>The infection control policy includes a surveillance policy including a surveillance procedure, process for detection of infection, infections under surveillance, outbreaks and quality and risk management. Infection events are collected monthly and entered onto the SWAY 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 Somerset facilities of similar size and benchmarking results are fed back to the infection control officer and used to identify areas for improvement. Surveillance results are used to identify infection control activities and education needs within the facility.</p> <p>There had been an outbreak of influenza like symptoms in August 2017. A section 31 report was sighted.</p>
Standard 2.1.1:	FA	There are policies around restraints and enablers. Four hospital level residents were using restraints (three lap

<p>Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>		<p>belts and one bedrail) and three hospital level residents had voluntarily requested bedrails as enablers. One resident file where an enabler was in place was selected for review. Evidence was sighted to verify voluntary consent by the resident for the bedrails. A restraint assessment had been completed that identified potential risks. The use of the enabler was linked to the resident's care plan. The enabler was reviewed by the restraint coordinator once a month. Monitoring of the enabler had been put into place.</p> <p>The clinical nurse lead is the designated restraint coordinator. Staff receive mandatory training around restraint minimisation that includes annual competency assessments.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>The restraint coordinator reviews restraint-use monthly. Reviews include aspects of criterion 2.2.4.1 (a-k). The restraint coordinator signs and dates each evaluation of restraint use. These are improvements from the previous certification audit. Restraint use is a regular agenda item in the monthly RN meetings.</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 1.2.7.4 New service providers receive an orientation/induction programme that covers the essential components of the service provided.	PA Low	Staff interviewed reported that they complete an orientation programme, but staff files reviewed were missing evidence of this.	Three of five staff files reviewed of staff who were hired during the first six months of 2017 were missing evidence of a completed orientation programme.	Ensure all staff submit evidence of completing an orientation programme.  90 days
Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing,	PA Low	All medication charts on the electronic medication system had photo identification and an allergy status recorded. Regular medications charted met legislative prescribing requirements. Medication charts had been reviewed at east three monthly. Oxygen therapy had	The oxygen therapy had not been prescribed for one hospital resident on continuous oxygen.	Ensure oxygen therapy is prescribed.

dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.		not been prescribed for one resident.		30 days
<p>Criterion 1.3.12.5</p> <p>The facilitation of safe self-administration of medicines by consumers where appropriate.</p>	PA Low	Three self-medicating residents (one hospital and two rest home) had been assessed as competent to self-medicate by the RN and GP, however, two competencies had not been reviewed.	Two self-medicating resident competencies (rest home) had not been reviewed by the RN and GP three monthly.	<p>Ensure self-medication competencies are reviewed three monthly.</p> <p>30 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Low	Monitoring forms are used to monitor residents' health and well-being including blood pressure and pulse, weight, neurological observations blood sugar levels, behaviour, food and fluid intake. Short-term care plans are used to document short-term needs and supports. Short-term care plans sighted on the day of audit included skin infection, wounds and skin tear, pressure injury risk. These had been reviewed regularly and signed off when resolved or transferred to the long-term care plan.	(i) There were no documented interventions in place for one resident with pressure injuries on admission. There were no documented interventions for two rest home residents and one hospital resident with identified pain. (ii) There were no weights taken on admission for two rest home residents.	<p>(i) Ensure interventions are documented for short-term needs and supports. (ii) Ensure weights are taken on admission.</p> <p>90 days</p>

## 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.