

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 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 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: 11 December 2018 End date: 11 December 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:	43



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 (geriatric and medical) level care for up to 63 residents. On the day of the audit, there were 43 residents, including two rest home residents in serviced apartments. The service is managed by a village manager and the care centre manager. 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 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 village manager (non-clinical) is appropriately qualified and experienced and is supported by the care centre manager (registered nurse) who oversees the care centre.

The service has addressed the one previous shortfall around care planning.

This audit has identified improvements are required around sharing information with staff, the orientation process 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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Residents and family are kept informed. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. Complaint processes are implemented, and complaints and concerns are actively managed and well documented.

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 are responsible for day-to-day operations. Goals are documented for the service with evidence of regular reviews. A quality and risk management programme is embedded in practice. Corrective actions are implemented and evaluated where opportunities for improvements are identified.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. An education and training plan is being implemented that includes in-service education and competency assessments.

Registered nursing cover is provided 24 hours a day, 7 days a week.

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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Care plans are individually developed by the registered nurse with resident and family/whānau involvement included, where appropriate. Care plans are evaluated six-monthly or more frequently when clinically indicated. Residents and family interviewed confirmed that the care plans are consistent with meeting residents' needs. The interRAI assessment tool is utilised and monitoring forms are available to assess effectively the level of risk and support required for residents. Activities provided are meaningful and ensure that the resident maintains involvement in the community. There is a documented medication management system. There are three-monthly GP medication reviews. The menu is designed by a dietitian and has seasonal menus. Dietary requirements are provided where special needs are required.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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There are documented processes for the management of waste and hazardous substances in place and incidents are reported in a timely manner. Chemicals are stored safely throughout the facility. The building has a current warrant of fitness.

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 three hospital-level residents requiring the use of bedrails as a restraint at the time of 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.
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Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

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	1	0	0
Criteria	0	38	0	2	1	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 organisational complaints policy states that the village manager has overall responsible for ensuring all complaints (verbal or written) are fully documented and investigated. There is an electronic complaint's register that includes relevant information regarding the complaint. Documentation includes follow-up letters and resolution. The number of complaints received each month is reported monthly to staff via the various meetings.</p> <p>There were five complaints received in 2018 (year to date). All five complaints were reviewed. Timeframes for responding to these complaints met Health and Disability Commissioner (HDC) guidelines and all five complaints were documented as resolved.</p> <p>Feedback forms are available for residents/relatives in various places around the facility.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	FA	<p>Nine residents (two hospital level and seven rest home level) and five family (all hospital level) interviewed stated they were welcomed on entry and were given time and explanation about services. Family members interviewed also stated they are kept informed of changes in the health status of their family member (resident) and of any incidents/accidents. Resident/family meetings are held monthly with an advocate from Age Concern present at the meeting every three months. The village manager and the care centre manager (CCM) have an open-door policy.</p>

<p>conducive to effective communication.</p>		<p>Evidence of open disclosure was sighted in all ten electronic accident/incident forms reviewed. The service produces a newsletter for residents and relatives. Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so.</p> <p>The service has policies and procedures available for access to interpreter services for residents (and their family/whānau). If residents or family/whānau have difficulty with written or spoken English, the interpreter services are made available. Family and/or staff are used in the first instance.</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 care for up to 63 residents at hospital (geriatric and medical) and rest home levels of care. There are 43 dual-purpose beds, all based in the care centre on level one. Twenty serviced apartments are certified for rest home level of care and are located on the ground floor. On the day of the audit, there were 43 residents. The care centre had 18 rest home level and 23 hospital level residents. Two residents in the serviced apartments were rest home level. One resident (hospital level) was on ACC and one resident (hospital level) was on respite. The remaining residents were under the aged related care contract.</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. Summerset at Bishopscourt has a site-specific 2018 business plan and goals. The quality plan is reviewed regularly throughout the year. There is a full evaluation at the end of the year.</p> <p>The village manager has been in his role at Summerset since 2013. He is supported by a care centre manager (CCM)/registered nurse (RN). The CCM has been in the position for three weeks. She holds post graduate qualifications in health sciences/nursing and long-term condition management and has 23 years of experience in aged care. The CCM is supported by a clinical (nurse) lead.</p> <p>The managers have completed at least eight hours of leadership 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 maintained quality and risk management system that reflects</p>	<p>PA Low</p>	<p>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>The Summerset group requires the implementation of a 2018 clinical audit, training and compliance calendar. This is being implemented at Bishopscourt. The internal audit programme covers aspects of clinical care. Issues arising from internal audits are developed into corrective action plans. Monthly and annual analysis of results is completed and communicated across the organisation. There are monthly accident/incident</p>

<p>continuous quality improvement principles.</p>		<p>benchmarking reports that break down the data collected across the rest home and hospital and staff incidents/accidents. Infection control is also included as part of benchmarking across the organisation.</p> <p>There is a meeting schedule that includes RN meetings (monthly), caregiver meetings (monthly or fortnightly) and quality improvement meetings (monthly). Meeting minutes document discussions regarding internal audit results, incident trends and complaints received. Missing in the meeting minutes was evidence of infection rates and restraint use being discussed.</p> <p>There is a health and safety and risk management programme in place including policies to guide practice. The activities coordinator is the health and safety representative. Health and safety meetings are scheduled three-monthly. The hazard register is reviewed on a regular basis.</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>Accidents and incidents are lodged electronically. Ten resident related incident reports were reviewed. All reports and corresponding resident files reviewed evidence that appropriate clinical care had been provided following the adverse event. Data is linked to the organisation's benchmarking programme and is used for comparative purposes.</p> <p>Discussions with the village manager and CCM confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There has been one section 31 for a pressure injury.</p>
<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>	<p>PA Low</p>	<p>There are human resources management policies in place that include the recruitment and staff selection process. Relevant checks are completed to validate the individual's qualifications, experience and veracity. Copies of current practising certificates are retained. Five staff files (three RNs and two caregivers) reviewed evidenced implementation of the recruitment process, employment contracts and annual performance appraisals.</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 new staff completing designated competencies and an induction checklist. Staff interviewed were able to describe the orientation process and remarked that new staff were adequately orientated to the service. Missing in staff files was documented evidence that their orientation programme had been completed.</p> <p>There is an annual education plan that is being implemented. The competency programme is ongoing with</p>

		different requirements according to work type. A record of competencies completed is maintained in the staff files.
<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>Staffing levels and skills mix policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery. The village manager and CCM work 40 hours per week, Monday to Friday and are available on call for any emergency issues or clinical support. The clinical nurse lead works full time, Monday – Friday. Her schedule is flexible to include weekend cover if required.</p> <p>In the care centre, there is a minimum of one RN on duty 24/7 with two RNs staffed on the AM shift. There are six caregivers on morning shifts (three long shifts and three short shift), six on the afternoon shifts (three long shifts and three short shift) and two on night shifts. Laundry is completed separately by laundry staff.</p> <p>The RN on duty provides oversight to the rest home residents in the serviced apartments. One caregiver is on duty in the serviced apartments on a morning shift and one on the afternoon shift. The night shift staff in the serviced apartments is delegated to a caregiver by the RN.</p> <p>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>Interviews with residents and relatives confirmed that staffing levels are sufficient to meet the needs of residents.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	PA Moderate	<p>Bishopscourt has implemented an electronic medication system. Ten medication charts were reviewed. There are policies and procedures in place for safe medicine management that meet guidelines. The registered nurse and pharmacist complete medication verification on delivery and a registered nurse completes reconciliation. 'As required' medications have been prescribed on the electronic system and have documented indications for use. Registered nurses and care staff interviewed were able to describe their role around administration of medications and completion of annual competencies. Medications were stored safely, and medication fridges were monitored weekly. Eye drops are dated on opening.</p> <p>Standing orders are not used and no residents self-administer. However, not all resident medication charts meet requirements.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p>	FA	<p>The service has a current food control plan which expires on 28 February 2019. The service has a large kitchen and equipment is well maintained. There are two fully qualified chefs, and all of the kitchen hands have food handling qualifications. There is a twelve-week seasonal menu approved by the dietitian. Special diets</p>

<p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>are catered for and documented in the kitchen.</p> <p>Food safety information and a kitchen manual are available. Food served on the day of audit was well presented. The main meal is served at tea time with a light ploughman type meal served at lunchtime. The chef interviewed reports this has had a positive impact in resident weights. The service encourages residents to express their likes and dislikes; a register of this is kept on file, with a whiteboard for new changes. Fridge/freezer and food temperatures are checked daily. The kitchen was clean and all food was stored off the floor. Chemicals were locked away. Meals are transported to the care centre via hot boxes, food temperatures are checked on leaving the kitchen and on serving in the care centre.</p> <p>The residents have a nutritional profile developed on admission by a registered nurse who identifies dietary requirements and likes and dislikes. Five files reviewed had up to date nutritional documentation and a copy was maintained in the kitchen. All family members and residents interviewed expressed satisfaction with the meals.</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>Residents interviewed reported their needs were being met. Relatives interviewed also stated their relative's needs were being appropriately met. When a resident's condition alters, the registered nurse initiates a review and if required, a GP visit or nurse specialist consultant review. Electronic care plans are updated to reflect the resident's current health status. Care plans reviewed in the resident files sampled, reflected the resident's current supports and needs. The previous finding has been addressed.</p> <p>Wound assessments and ongoing evaluations were in place on the electronic system for all current wounds including two pressure injuries (one stage III and one stage I). Adequate dressing supplies were sighted in the treatment rooms. Wound care advice and support can be readily sought from the DHB wound specialist nurse.</p> <p>Continence products are available and resident files include a continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the RNs interviewed.</p> <p>Monitoring forms in place include (but not limited to): monthly weight, blood pressure and pulse; food and fluid charts; restraint monitoring; pain monitoring; blood sugar levels; and behaviour charts.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity</p>	<p>FA</p>	<p>The service employs two recreational therapists to provide an activity programme across seven days for the rest home and hospital level of care residents. Both activity persons have current first aid certificates.</p> <p>The programme is planned a month in advance and has the flexibility to add other activities of interest or suggestions made by residents. Activities meet the recreational needs of both resident groups ensuring all residents have the opportunity for outings into the community. Other activities include a variety of exercises,</p>

<p>requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>newspaper reading, housie, quizzes, movies, baking, crafts and happy hours. Community visitors include weekly entertainers, church services, volunteers and the monthly SPCA dog visit. The recreational therapists ensure daily contact is made with residents who choose to stay in their rooms and for those residents in serviced apartments. Specific individual activities are provided for the younger people within the care centre.</p> <p>Care centre residents continue to be invited to participate in village activities and village residents visit the care centre and participate. The recreational therapist interviewed describes more residents (around 10-15 at times) from the serviced apartments and the wider village participating in the live entertainment, special events, and happy hours. Some of the residents from the serviced apartments and the village play musical instruments and provide entertainment for the care centre residents.</p> <p>Residents are encouraged to maintain their former community links. Church services are held in the family/whānau room. The service has a wheelchair van for the rest home and hospital resident outings.</p> <p>Monthly meetings provide an opportunity for residents to feedback on the programme. A new initiative of having separate relatives' meeting has been held, and provided positive feedback and suggestions for the programme. This is planned to be held quarterly. As a result of the relatives' meetings, a new addition to the welcome pack has been developed to contain information on "house rules" such as timing of visits from health professionals, and streamlining communication with family members.</p> <p>The service continues to make improvements around the presentation of the planner, and more focus on small group visits for people with special interests such as auctions and the art gallery. The residents have put a calendar together of them participating in activities and some photos from their outings. A new initiative to send families a photograph of residents on their birthday has been well received.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>There is evidence of resident and family involvement in the review of resident centred care plans. All initial care plans reviewed had been evaluated by the registered nurses within three weeks of admission. The GP completes three-monthly reviews. Long-term care plan evaluations were completed six-monthly or earlier for resident health changes in all files reviewed. There is evidence of multidisciplinary (MDT) team involvement in the reviews including input from the GP and any allied health professionals involved in the resident's care. Relatives 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.</p>
<p>Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate,</p>	<p>FA</p>	<p>The building has a current building warrant of fitness that expires on 5 May 2019.</p> <p>The building has three levels with serviced apartments on the ground floor, care centre on the first floor and independent apartments on the second level. There is a full-time maintenance person who oversees the property and gardening team and is available on call for facility matters. A 52-week planned maintenance</p>

<p>accessible physical environment and facilities that are fit for their purpose.</p>		<p>schedule includes equipment checks, testing and tagging of electrical equipment and calibration of medical equipment. There is a system in place to report maintenance and repair requests. Hot water temperatures are tested and recorded monthly with readings maintained below 45 degrees Celsius. Preferred contractors for essential services are available 24/7.</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. There is an outdoor balcony with seating and shade. The external areas are well maintained.</p> <p>The caregivers and registered nurses interviewed stated they had all the equipment required to safely provide the care documented in the care plans.</p>
<p>Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The infection control officer has recently resigned, and a new infection control officer has been appointed during the changeover.</p> <p>The infection control policy includes a surveillance policy which documents a surveillance procedure, process for detection of infection, infections under surveillance, outbreaks and quality and risk management. Infection events are recorded on hard copy, collected monthly, and entered onto the electronic system. Areas for improvement are identified and corrective actions are developed and followed up. However, there has been a gap identified in staff meeting minutes around reporting infection control data, trends and corrective actions (link 1.2.3.6). 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. Surveillance results are used to identify infection control activities and education needs within the facility.</p> <p>The service continues to monitor outcomes of the rate of urinary tract infections (UTIs), to remain under the national benchmark (previous continuous improvement). There were no residents with UTI from December 2017 to June 2018. There was a peak noted between June and July with no further UTIs through September or October 2018.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policies and procedures include definitions of restraint and enabler that are congruent with the definition in NZS 8134.0. The service has documented systems in place to ensure the use of restraint is actively minimised. There were three hospital level residents using restraints (bedrails) and no residents using an enabler at the time of the audit.</p> <p>The clinical nurse lead is the restraint coordinator. She is new to this role. She understands strategies around restraint minimisation. Staff interviews and staff records evidenced guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques. Staff</p>

		<p>education including assessing staff competency on RMSP/enablers has been provided.</p> <p>Restraint is scheduled to be discussed as part of staff meetings and in separate restraint meetings, but this has not occurred since May 2018 (link 1.2.3.6).</p>
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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 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	Following the departure of the previous clinical nurse manager in May 2018; infection control meetings and restraint minimisation meetings ceased. Data relating to infections and restraint use were not minuted after this date as evidenced in the quality, RN and caregiver meeting minutes.	Data relating to infections and restraint use were not minuted after May 2018 as evidenced in the quality, RN and caregiver meeting minutes.	Ensure that care staff are kept informed regarding quality results, including infection control and restraint minimisation data. 90 days
Criterion 1.2.7.4	PA Low	Interviews with staff and management confirmed that an orientation programme is in place for new staff. However, none	Staff reported that they had completed	Ensure staff files contain

<p>New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p>		<p>of the five staff files selected for review indicated that staff had completed their orientation to the service. The village manager reported that staff are not handing in their orientation booklets in after completing their orientation programme.</p>	<p>an orientation programme but there was no evidence in the five staff files reviewed to confirm this.</p>	<p>documented evidence of staff completing their orientation programme.</p> <p>90 days</p>
<p>Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA Moderate</p>	<p>The medications charts on the electronic system have been charted and signed by the GP. Each chart on the electronic system shows evidence of a three-month review, photo identification, and have allergies documented. However, the paper medication charts for two residents in the serviced apartments and one respite resident do not meet requirements. Signing sheets have been fully completed in the paper records. The CCM had identified the issues and has sent a notification to the GPs.</p>	<p>(i) All three paper-based medication charts for two rest home level care residents in the serviced apartments and the respite resident have not been signed by the GP. (ii) Allergies have not been documented on the medication charts for the two rest home residents in the serviced apartments and the respite resident. (iii) There was no photo identification in the paper-based medication charts for the two rest home resident files in the serviced</p>	<p>(i)-(iii) Ensure that paper-based medication charts are signed by the GP and contain photo identification and documented allergies.</p> <p>30 days</p>

			apartments.	
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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.