

# Summerset Care Limited - Summerset at Wigram

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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 at Wigram

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

**Dates of audit:** Start date: 12 December 2018 End date: 13 December 2018

**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:** 55

# 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 at Wigram provides rest home and hospital (geriatric and medical) level care for up to 52 residents in the care centre and for up to 53 residents at rest home level of care in the serviced apartments. On the day of the audit there were 55 residents in total.

This unannounced surveillance audit was conducted against a subset of the Health and Disability Standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of resident's and staff files, observations and interviews with residents, family members, staff, management and the general practitioner.

The village manager is appropriately qualified and experienced and is supported by an experienced care centre manager who oversees the care centre. The residents and relatives interviewed spoke positively about the care and support provided.

The four previous findings regarding care plans, medication, restraint assessments and monitoring have been addressed.

There were no new findings at this surveillance audit.

## 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 well informed including of changes in residents' health. Residents'/family meetings are held monthly. Management have an open-door policy. Complaints and concerns have been managed and a complaints register is maintained.

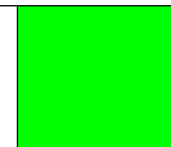
## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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The quality and risk management programme has been embedded and includes a philosophy, goals and a quality planner. Meetings are held to discuss quality and risk management processes and quality data. There is a health and safety management programme available to guide staff. Incidents and accidents are reported. There are human resources policies to support recruitment practices. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. An education and training programme have been completed for 2018. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.



Standards applicable to this service fully attained.

The registered nurses are responsible for each stage of provision of care. Assessments, resident care plans, and evaluations were completed by the registered nurses within the required timeframes. Risk assessment tools and monitoring forms were available and implemented. Resident care plans were individualised and included allied health professional involvement in resident care.

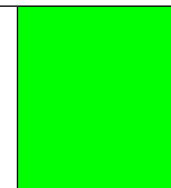
Recreational therapists coordinate an integrated activity programme that meets the individual recreational needs and preferences of the resident groups. There are outings into the community and visiting guests/entertainers.

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.

The building has a 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 are in place to guide staff in the use of an approved enabler and/or restraint. On the day of audit, there was one resident with a restraint and three residents using an enabler. Staff training has been provided around restraint minimisation and management of challenging behaviours.

## 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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The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. These included audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Somerset facilities. There have been no outbreaks.

## 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	19	0	0	0	0	0
Criteria	0	45	0	0	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	The organisational complaints policy states that the village manager has overall responsibility for ensuring all complaints (verbal or written) are fully documented and investigated. A complaints procedure is provided to residents within the information pack at entry. Feedback forms are available for residents/relatives in various places around the facility. There is an electronic complaints' register that includes relevant information regarding the complaint including investigation and resolution. There have been six care centre complaints received since the last audit. The complaints have been acknowledged and followed up within the required timeframes.
Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment	FA	Four residents (three rest home and one hospital level) and two relatives (of hospital level residents) interviewed, confirmed they were given an explanation about the services and procedures. There are monthly resident meetings and quarterly advocate meetings where all services are discussed, and residents have the opportunity to provide feedback and suggestions on services and care. Residents and relative receive a monthly newsletter.  Accident/incidents, complaints procedures and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident. Seven incidents/accident forms for October 2018 were reviewed in the resident electronic register. All forms evidenced family were informed or if family did not wish to be informed. Relatives interviewed confirmed that they are notified of any changes in their family member's health status. An



conducive to effective communication.		interpreter policy and contact details of interpreters is available. Interpreter services are used where indicated.
<p><b>Standard 1.2.1: Governance</b></p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Summerset at Wigram provides rest home and hospital level of care for up to 52 residents in the care centre (first level) and up to 53 residents at rest home level of care (20 on the ground floor and 33 on the second level). On the day of the audit, there were 46 residents in the care centre. There were 15 rest home and 31 hospital level residents (including four on an end of life contract and one rest home respite care). There were eight rest home level residents and one rest home respite care in the serviced apartments. All other residents were under the aged related residential care (ARRC) contract.</p> <p>Summerset group has a well-established organisational structure. Each of the Summerset facilities throughout New Zealand is supported by this structure. The Summerset group has a comprehensive suite of policies and procedures, which will guide staff in the provision of care and services. 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 Wigram has a site-specific 2018 business plan and goals that is developed in consultation with the village manager, care centre manager and regional operations manager. The business plan has been reviewed quarterly with the management team. Specific goals around communication, resident care, health and safety, food services and activities have been achieved with 100% resident/relative satisfaction in the 2018 survey.</p> <p>The service has a village manager who has been in the role for two years when the main building opened. He had previously been in management roles for other Summerset villages. The village manager reports weekly to the regional manager who is on-site monthly. The village manager is supported by an experienced care centre manager (RN) who has been in the role since July 2016.</p> <p>The village manager and care centre manager have attended at least eight hours of leadership professional development relevant to their roles.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects</p>	FA	<p>Summerset at Wigram have an established organisational quality and risk management system. There are policies and procedures being implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. The content of policy and procedures are detailed to allow effective implementation by staff. Policies are reviewed on a regular basis at head office. The Summerset group has a 'clinical audit, training and compliance' calendar. The calendar schedules the training and audit requirements for the month and the care centre manager forwards a monthly report to head office as part of the ongoing monitoring programme.</p> <p>Annual residents/relatives survey for 2017 and September 2018 resulted in an overall satisfaction rate of 99.3%. Summerset at Wigram rates above the overall satisfaction rate for all of Summerset villages at 95.4%.</p> <p>There is a meeting schedule including (but not limited to): monthly quality improvement; full facility meetings</p>

continuous quality improvement principles.		<p>monthly; and monthly registered staff and enrolled nurse meetings that include discussion about clinical indicators (eg, incident trends, infection rates, complaints). Caregiver meetings have been re-established following the outcome of a staff survey. Health and safety, infection control and restraint meetings have occurred monthly.</p> <p>The service has an internal audit programme that includes (but not limited to) aspects of clinical care. Issues arising from internal audits are developed into corrective action plans and there are re-audits as required. Monthly and annual analysis of results is completed and provided across the organisation. There are monthly accident/incident benchmarking reports completed by the care centre manager 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>Summersets clinical and quality manager analyses data collected via the monthly reports and corrective actions are required based on benchmarking outcomes. There is a health and safety and risk management programme in place including policies to guide practice. The village manager has completed the first health and safety (H&amp;S) representative course in October 2018. The property manager is the health and safety representative (interviewed) who has completed the three H&amp;S courses and site safety certificate. The Health and Safety Committee comprise of a H&amp;S representative from each department and meet monthly to review incidents and hazards and H&amp;S objectives. One of the 2018 H&amp;S objective was to reduce the number of shoulder and lower back strains. The clinical team complete pre-shift stretches as observed on the day of audit. While there has been a reduction in staff incidents, the data is yet to be formally evaluated. The hazard register has been reviewed June 2018 by the H&amp;S Committee. The committee is supported by the national H&amp;S Committee at head office. Each month there is a health and safety "golden rule" focus and staff are provided with resources and education that is available on the H&amp;S staff noticeboard.</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. The service has appointed an RN falls prevention coordinator July 2017. She reviews all falls incidents, trends and analysis of time, location and resident's health status. The Falls Committee of two morning, two afternoon and two night shift care staff have commenced monthly meetings. The falls prevention coordinator liaises with the physiotherapist who completes initial assessments for all residents and involved in post falls assessments and recommendations.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically</p>	FA	<p>Incident and accident data is being collected and analysed. A review of seven incident/accident forms (electronic) for October 2018 identified they were all fully completed, including a timely assessment and follow up by a RN and relative notification. Post falls assessments included neurological observations for four unwitnessed falls with potential head injury were reviewed. The incident reporting policy includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Data is linked to the organisation's benchmarking programme and used for comparative purposes. Discussions with the management team confirmed that there is an awareness of the requirement to notify relevant authorities in relation</p>

recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.		to essential notifications. There has been one section 31 notification completed since the last audit for absconding. Appropriate interventions were implemented.
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are human resources policies to support recruitment practices. Six staff files (one care centre manager, one RN, one clinical nurse leader, two caregivers and one recreational therapist/caregiver) were reviewed and all had relevant documentation relating to employment. There were current annual practising certificates for all qualified staff and allied health professionals. Performance appraisals have been completed annually. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and believed new staff were orientated well to the service. One senior caregiver is a caregiver coach supporting new care staff to the service.</p> <p>There is an annual education plan that is outlined on the 'clinical audit, training and compliance calendar'. The education plan covering mandatory education and training and additional in-service has been completed for 2018 with good attendance numbers. A competency programme is in place with different requirements according to work type (eg, caregivers, RNs and kitchen). Core competencies are completed, and a record of completion is maintained. The service has six of eleven RNs (including the care centre manager and clinical nurse leader) trained in interRAI. Staff interviewed were aware of the requirement to complete competency training.</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 village manager and care centre manager work 40 hours per week, Monday to Friday and are available on-call for any emergency issues or clinical support. In the care centre, there is an RN on duty 24/7 and an enrolled nurse on five mornings and four afternoon shifts per week. There are eight caregivers on morning shifts (four full shifts and four short shifts). There are six caregivers on the afternoon shifts (four full shifts and two short shifts) and two caregivers on night shifts. The RN on duty provides oversight to the rest home residents in the serviced apartments. There is one caregiver on duty 24 hours for the rest home residents in the serviced apartments (four permanent residents and one respite care on the ground level and four permanent residents on the second level).</p> <p>A staffing levels and skills mix policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery. A staff availability list ensures that staff sickness and vacant shifts are covered. Caregivers interviewed confirmed that staff are replaced when off sick.</p> <p>Interviews with residents and relatives confirmed that staffing levels are sufficient to meet the needs of residents.</p>

<p><b>Standard 1.3.12: Medicine Management</b></p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<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 are responsible for the administration of medications and have completed medication competencies (including syringe driver) and annual medication education. Caregivers complete medication competencies for the checking and witnessing of medications as required. All medications (for the care centre and serviced apartment rest home residents) are stored safely in the one main medication room in the care centre.</p> <p>Regular medications are delivered in robotic rolls and were evidenced to be checked on delivery with any discrepancies fed back to the supplying pharmacy. There was one self-medicating resident who had a current self-medication assessment, medications stored in locked drawer and monitoring completed as required. The medication chart identified the self-administering medications. The previous finding around self-administering has been addressed. All eye drops sighted in the two trolleys had been dated on opening. The medication fridge is monitored daily with corrective actions recorded for unacceptable temperatures.</p> <p>Ten resident medication charts on the electronic medication system were reviewed. Corresponding medication administration sheets including the respite resident evidenced medications were administered as prescribed. The previous finding around administration of medications has been addressed. The medication charts had photograph identification and allergy status recorded. Staff recorded the time, date and effectiveness of 'as required' medications. All 'as required' medications had an indication for use. All medication charts had been reviewed by the GP three-monthly.</p>
<p><b>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</b></p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The service has a contracted company for the provision of all meals on-site and the café. The service has a food control plan that has been verified for 18 months and expires August 2019. The seasonal 12-weekly menu has been reviewed by the contracted dietitian. The menu meets the resident preferences and resident dietary requirements including dislikes. The main meal is in the evening. Meals are delivered in a hot box to the care centre kitchenette where meals are served from the bain marie. The chef serves the meals at least twice-weekly. The chef receives a dietary profile for each resident and notified of any changes including weight loss and provides smoothies and added calories such as cream/ice-cream to foods. Gluten free meals and pureed foods are provided. Care staff were observed to be assisting residents with their meals in the dining room.</p> <p>The fridge, freezer and chiller temperatures are taken and recorded twice-daily. End-cooked food temperatures and serving temperatures are taken and recorded. All foods are stored correctly, and date labelled. Cleaning schedules are maintained. Staff were observed wearing correct personal protective clothing. Staff working in the kitchen have completed food safety September 2018.</p> <p>Residents have the opportunity to feedback on meals through direct feedback and resident meetings. Residents</p>

		and relatives commented positively on the food services and meals.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Care plans reviewed on the electronic resident care system described the individual support and interventions required to meet the resident's goals. The initial support care plans for all residents and long-term care plans for long-term residents reflected the outcomes of risk assessment tools and interRAI assessments. The initial support plan for the rest home respite care resident reflected the outcomes of the initial assessment including supports required for high falls risk and pain management. The previous finding around documented interventions to meet the residents needs/goals has been addressed. Short-term care plans are used for changes to health and were sighted in use for wounds, weight management and infections.</p> <p>Care plans demonstrate service integration and include input from allied health practitioners.</p> <p>There is documented evidence of resident/family/whānau involvement in the care planning process. Residents/relatives interviewed confirmed they participate in the care planning process.</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>	FA	<p>When a resident's condition changes, the RN initiates a review and if required a GP or nurse specialist consultation. Relatives interviewed stated their relative's needs are being met and they are kept informed of any health changes. There was documented evidence in the electronic resident progress notes of family notification of any changes to health including; infections; accidents/incidents; medication changes; GP visits; and family meetings. Residents interviewed stated their needs are being met.</p> <p>Adequate dressing supplies were sighted. Initial wound assessments with ongoing wound evaluations and treatment plans were viewed in V-care for 8 of 13 wounds. Short-term care plans were in place for wounds. One chronic wound was linked to the long-term care plan. There were no pressure injuries. There is wound nurse specialist advice and support available at the DHB. Adequate pressure injury resources are available and were observed to be in place for residents assessed at high risk of pressure injury.</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 completed on the electronic resident system. Work logs entered onto the system alert staff of monitoring requirements and these are signed off as completed. Registered nurses review the monitoring charts, which include: pain monitoring; neurological observations; bowel monitoring; re-positioning charts; restraint monitoring; food and fluid intake monitoring; and weights.</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 three recreational therapists (RT) who are qualified diversional therapists to coordinate and implement the integrated rest home/hospital activity programme over seven days. The programme is resident driven, flexible and planned with feedback and suggestions from the resident monthly meetings. All residents (including those in the serviced apartments) receive an activity programme. Rest home residents may attend the care centre or serviced apartment activity programme. Volunteers (including village residents) assist with house, outings, one-on-one resident activities, walks, hand and nail cares. The RTs make daily contact with residents who choose not to join in with activities. Other activities included in the programme are: board games; quizzes; baking; walks; movies; news reading; reminiscing; cards; happy hour; arts and crafts; exercises with the physio; Tai Chi; book club; and knitter-knatter group. Events and themes are celebrated with resident and staff participation such as Melbourne Cup and Christmas.</p> <p>Community visitors include pre-school children, entertainers, church groups and pet therapy visits. There are regular outings into the community for events and functions such as vintage car drives and raising funds for Alzheimer's, scenic drives and visits to cafes. A mobility van is hired for hospital level residents unable to access the van.</p> <p>There is a recreational assessment and activity plan in place for all long-term resident files reviewed. The RTs are involved in the MDT six-monthly review of the resident's care plan and activity plan. The residents and relatives interviewed expressed satisfaction with the programme, which reflected resident preferences.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>All initial care plans were evaluated by the RNs within three weeks of admission. There is evidence of resident and family involvement in the evaluation of the initial care plan and the six-monthly care plans. The multidisciplinary team includes care staff, RT and any allied health professionals such as the GP and physio involved in the care of the resident. Written evaluations for long-term residents had been completed six-monthly against the resident goals and record if the goals have been met or unmet. The GP completes three-monthly reviews.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit</p>	FA	<p>The building has a current building warrant of fitness which expires 1 August 2019. There is a reactive and planned maintenance programme in place.</p>

for their purpose.		
<p><b>Standard 3.5: Surveillance</b></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 into the electronic system. The infection control coordinator (RN) has been in the role three weeks and supported by the care centre manager to provide infection control data, trends and relevant information to the monthly Infection Control Committee. The monthly, three-monthly, six-monthly and annual analysis of infection events, trends and analysis are reviewed by management, and data is forwarded to head office for benchmarking. Areas for improvement are identified, corrective actions developed and followed up. Infection control audits are completed, and corrective actions signed off. Surveillance results are used to identify infection control activities and education needs within the facility. There have been no outbreaks.</p>
<p><b>Standard 2.1.1: Restraint minimisation</b></p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. Interviews with the caregivers and nursing staff confirmed their understanding of restraints and enablers. The service currently has one resident assessed as requiring the use of restraint (lap belt) and four residents using enablers (lap belts). Residents voluntarily request and consent to enabler use. Two of four resident files using enablers were reviewed and included an assessment and consent for use of an enabler. Staff training has been provided around restraint minimisation and management of challenging behaviours. Staff complete restraint competencies.</p>
<p><b>Standard 2.2.2: Assessment</b></p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>A restraint assessment tool was completed for the one resident on restraint (lap belt). The restraint coordinator in partnership with the RNs, GP, resident and their family/whānau, undertakes assessments. Restraint assessments are based on information in the care plan, resident/family discussions and observations. Ongoing consultation with the resident and family/whānau are evident in the file reviewed. The completed assessments considered those listed in 2.2.2.1 (a) - (h). The previous finding around assessments has been addressed.</p>
<p><b>Standard 2.2.3: Safe Restraint Use</b></p> <p>Services use restraint safely</p>	FA	<p>Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint.</p> <p>Restraint authorisation is in consultation/partnership with the resident and family and the GP. The use of restraint,</p>

		risks and frequency of monitoring is documented in the care plan of the one resident with a lap belt restraint. The monitoring form is completed in the residents electronic file as reviewed. The previous finding around restraint monitoring has been addressed.
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## Specific results for criterion where corrective actions are required

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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.

No data to display
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display
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End of the report.