

Summerset Care Limited - Summerset At Bishopscourt

Introduction

This report records the results of a Certification 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: 17 March 2020 End date: 18 March 2020
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	44

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

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

General overview of the audit

Summerset at Bishopscourt provides rest home and hospital level care for up to 42 residents in the care centre and up to 20 rest home residents in the serviced apartments. On the day of the audit there were 40 residents in the care centre and four rest home residents in the serviced apartments. The residents and relatives interviewed spoke positively about the care and support provided.

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

The service is managed by a non-clinical village manager who has been in the role since 2013, and a care centre manager (RN) who has been in the role since November 2019. The management team is supported by a regional operations manager and regional quality manager, one experienced clinical nurse lead, a team of registered nurses and caregivers.

This audit identified no areas for improvement.

The service has achieved a continued improvement rating around quality initiatives.

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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Summerset at Bishopscourt provides care in a way that focuses on the individual resident. There is a Māori health plan and cultural safety policy supporting practice. Cultural assessment is undertaken on admission and during the review process. The service functions in a way that complies with the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and related services is readily available to residents and families. Policies are available that support residents' rights. Care plans accommodate the choices of residents and/or their family. Complaints processes are being implemented and complaints and concerns are managed and documented. Residents and relatives interviewed verified ongoing involvement with the community.

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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A quality and risk management system is in place. Key components of the quality management system link to a number of meetings including monthly quality improvement meetings. Annual surveys and resident meetings provide residents and families with an opportunity for feedback about the service. Quality performance is reported to staff at meetings and includes discussion about incidents, infections and internal audit results. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care. There is a staffing policy in place.

Continuum of service delivery

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.

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

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

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

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

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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Chemicals are stored safely throughout the facility. Appropriate policies are available along with product safety charts. The building holds a current warrant of fitness. Resident rooms are spacious with an adequate number of shower and toilet facilities for the number of residents including ensuites. There is wheelchair access to all areas. External areas are safe and well maintained. Fixtures, fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are well monitored through the internal auditing system. There is an emergency plan in place including fire safety and there are sufficient civil defence supplies in the event of a civil emergency.

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. There were seven residents using bedrails as restraint and one resident using an enabler on the day of audit. Consents, assessments and evaluations had been completed as per policy. Restraint minimisation, enabler use, and challenging behaviour training is included in the training programme.

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 is responsible for coordinating and providing education and training for staff. The infection control officer has attended external training. The infection control manual outlined the scope of the programme and included a comprehensive range of policies and guidelines. The infection control officer uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This included audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Somerset facilities. There has been one respiratory outbreak since the previous audit.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	50	0	0	0	0	0
Criteria	1	100	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
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Discussions with 13 care staff (three caregivers, three registered nurses, one clinical nurse lead, one cook, one maintenance, one housekeeping, one laundry assistant and two activities coordinators) confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Four residents (two hospital and two rest home including resident from the serviced apartments) and four relatives (hospital level) were interviewed and confirmed the services being provided are in line with the Code. All staff completed training around Code of Rights in August 2019. Observation during the audit confirmed this in practice.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed</p>	FA	<p>The seven admission agreements reviewed included written general and specific consents signed by either the resident or their EPOA at the time of admission. Residents and relatives confirmed informed consent had been discussed with them at the time of admission, they also commented carers sought consent when undertaking cares.</p> <p>Resident resuscitation forms were signed by the resident if competent or was a documented discussion with family/whānau when the resident was not competent, this was confirmed by the General Practitioner (GP). In discussion with the family members of two hospital level residents both identified the service involves them in the development of the resident's care plan.</p>

consent.		
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Residents are provided with a copy of the Code of Rights and access to advocacy services on entry to the service and leaflets are displayed around the facility. Residents interviewed confirmed they are aware of their right to access independent advocacy services and advocacy pamphlets are available at reception. Code of Rights and advocacy is discussed with residents and relatives on admission to the service. Meeting minutes are displayed on the resident noticeboard. The service provides opportunities for the family/enduring power of attorney (EPOA) to be involved in decisions as evidenced in the resident files reviewed. The resident files include information on residents' family/whānau and chosen social networks.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. Activities programmes included opportunities to attend events outside of the facility including activities of daily living, for example, shopping and attending cafés and restaurants. Interviews with staff, residents and relatives informed residents are supported and encouraged to remain involved in the community and external groups. Relatives and friends are encouraged to be involved with the service and care.</p>
<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 responsibility for ensuring all complaints (verbal or written) are fully documented and investigated including involvement from the care centre manager for clinical concerns/complaints. There is an electronic complaint register that included relevant information regarding the complaint. Documentation included acknowledgement, investigation, follow-up letters (offering advocacy) and resolution. There were seven complaints in 2019 including a complaint which had been referred to the HDC. The investigation for this complaint around resident care was completed by the regional quality manager. Letters sent to the family, minutes from meetings with the family and the HDC evidence are on file. The complaint has been left open and no further correspondence has been received from the family. All follow-up actions have been completed. One complaint has been received in 2020 (year to date). Complaints and concerns are discussed at the relevant facility meeting. A complaints procedure is provided to residents within the information pack at entry.</p> <p>Feedback forms are available for residents/relatives and there is a suggestion box available. Complaints are discussed at meetings as evidenced in the minutes. Staff attended an education session around consumer rights and complaints in August 2019. The caregivers interviewed could easily describe the complaints process by directing the complainant to the most senior member of staff on duty.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>The service provides information in the welcome pack to residents that includes the Code, complaints and advocacy. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Residents and relatives interviewed identified they are well informed about the Code of Rights. The Code of Rights (in English and Māori) are displayed near the nurses' station of the care centre and in the main corridor of the service apartments. Caregivers and nurses interviewed were knowledgeable around the role of the advocacy service and described instances where advocacy services would be utilised.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, 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>FA</p>	<p>Staff interviewed were able to describe the procedures for maintaining confidentiality of resident records, resident's privacy and dignity. Contact details of spiritual/religious advisors are available. Resident files include cultural and spiritual values. Residents and relatives interviewed reported that residents are able to choose to engage in activities, access community resources and are supported to attend church services. Staff were observed knocking on resident doors before entering the room. There is an elder abuse and neglect policy. Staff education around privacy and personal information education was held in October 2019. Abuse and neglect and advocacy is to be held in 2020 (held every two years).</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>Summerset has a Māori health plan that includes a description of how they achieve the requirements set out in the contract. There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with a neighbouring community marae. The service has access to advisors at the Māori health unit at the DHB and access to cultural education courses. There were two residents on the day of audit identifying as Māori, both had cultural preferences and iwi affiliations recorded in their care plan. Staff interviewed were able to describe how they would ensure they meet the cultural needs of residents identifying as Māori. Treaty of Waitangi and cultural safety is included in the education planner and was last completed in March 2019.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic,</p>	<p>FA</p>	<p>An initial care planning meeting is carried out where the resident and/or whānau as appropriate/able are invited to be involved. Individual beliefs or values are further discussed and incorporated into the care plan. Six monthly multi-disciplinary team meetings occur to assess if needs are being met, and relatives/EPOA are invited to attend. Discussion with relatives confirmed values and beliefs are considered. Residents interviewed confirmed that staff take into account their culture and values.</p>

cultural, spiritual values, and beliefs.		
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Staff job descriptions include responsibilities and staff sign a copy on employment. House rules and a code of conduct are included in the employment contract and staff sign a professional boundaries policy on employment. The staff and clinical meetings occur monthly and include discussions on professional boundaries and concerns as they arise. Management provide guidelines and mentoring for specific situations. Interviews with the village manager, care centre manager and clinical nurse leader confirmed an awareness of professional boundaries. Caregivers and RNs interviewed were knowledgeable around the scope of their role and responsibilities.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>Residents and relatives interviewed, spoke very positively about the care and support provided. Staff have a sound understanding of principles of aged care and stated that they are supported by the village manager and care centre manager.</p> <p>All Summerset facilities have a master copy of policies which have been developed in line with current accepted best practice and are reviewed regularly. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff. There is a quality improvement programme that includes performance monitoring against clinical indicators and benchmarking against like services within the group is undertaken. There is a culture of ongoing staff development with an in-service programme being implemented. Caregivers, once orientation has been completed, hold level two Careerforce unit standards. There is evidence of education being supported outside of the training plan. Registered nurses have access to external DHB and hospice training sessions. There is good liaison and working relationship with the DHB personnel and outside organisations such as the Hospice. Services are provided at Summerset that adhere to the Health & Disability services standards. There are implemented competencies for caregivers and registered nurses specific to their roles.</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>Residents and relatives stated they were welcomed on entry and were given time and explanation about services and procedures. Relatives interviewed also stated they are informed of changes in the resident's health status and incidents/accidents as evidenced in the electronic incident forms reviewed. Resident/relative meetings are held three monthly with an independent advocate. The village manager and the care centre manager have an open-door policy.</p> <p>Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. 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</p>

		with written or spoken English, the DHB interpreter services are made available.
<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>The service provides care for up to 42 residents at hospital (medical and geriatric) and rest home level care in the care centre and up to 20 rest home level of care residents in serviced apartments. On the day of the audit, there were 44 residents in the care centre with 12 at rest home level and 28 hospital level residents including two residents on ACC funding, one resident on respite, and one resident on end of life funding. All beds in the care centre are dual-purpose beds. There were four rest home residents in the serviced apartments.</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 business plan and goals that are developed in consultation with the village manager, care centre manager and regional quality manager. The plan is reviewed quarterly throughout the year. The 2019 plan has been reviewed and targets overall were met. The 2020 objectives include (but not limited to); increasing satisfaction rates for residents, engaging with staff increasing staff education, to reduce staff turnover and providing a safe supportive environment, increasing the rate of uptake of the flu vaccine.</p> <p>The village manager (non-clinical) has been in the role since 2013. The village manager is supported by a care centre manager/RN. The care centre manager has been in her role since November 2019, and has a background in mental health, surgical nursing and has managed a community-based service. The regional quality manager has been filling the temporary care centre manager role and has been orientating the current care centre manager to her role. The regional quality manager was present for the audit. They are supported by an experienced clinical nurse lead (CNL), and a team of registered nurses and caregivers.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>During a temporary absence the office administrator or a roving village manager will cover the village manager's role. The CNL will cover the care centre managers leave. The regional quality manager provides oversight and support. The care centre manager and CNL alternate weeks on-call and the village manager is available on-call for facility matters.</p>
<p>Standard 1.2.3: Quality And</p>	FA	<p>Summerset at Bishopscourt is implementing an organisational quality and risk management system. There are policies and procedures being implemented to provide assurance that the service is meeting accepted</p>

<p>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>	<p>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 from head office. The content of policy and procedures are detailed to allow effective implementation by staff. Staff are required to read and sign for new/reviewed policies.</p> <p>The Summerset group has a 'clinical audit, training and compliance' calendar. The calendar schedules the training and audit requirements for the month. The village manager and care centre manager complete monthly reports confirming completion of requirements. There is a meeting schedule including (but not limited to) monthly quality improvement meetings, staff meetings, registered nurse meetings and care staff meetings. The infection control coordinator provides a monthly report and health and safety committee meetings are held. Quality data such as infections, accidents/incident, hazards, restraint, audit outcomes, concerns/complaints are discussed and documented in meeting minutes. Meeting minutes and quality data reports and graphs are available to all staff. As a result of the HDC complaint, the service is currently implementing the Te Ara Whakapiri end of life care pathway. The clinical nurse specialist from the Hospice visits regularly and provides assistance, advice and education for staff around care of the dying person.</p> <p>The service is implementing an internal audit programme that includes environmental, infection control, health and safety, consumer rights and aspects of clinical care. Corrective action plans and re-audits are completed if audit results are less than expected. Monthly and annual analysis of results is completed and communicated to all staff.</p> <p>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. Infection control is also included as part of benchmarking across the organisation. Data is analysed and corrective actions are required based on benchmarking outcomes. The regional quality manager is alerted automatically through the RMSS system of any high-level accident/incidents (resident, staff and environmental). The service currently has quality initiatives around falls minimisation, palliative care, reducing restraint and reduction of polypharmacy.</p> <p>An annual residents/relatives survey has been completed for 2018 and reports 98.2% overall satisfaction rate. This reduced to 96.4% in 2019. However, the results did evidence improvements; the scale used is 1 (poor) to 5 (high). Personal care – 3.9 in 2017 to 4.1 in 2018 increasing to 4.2 in 2019. Meals increased from 3.4 in 2017, to 3.9 in 2018 to 4.0 in 2019. Activities has decreased slightly – 4.6 in 2017, 4.1 in 2018 to 4.0 in 2019. There were 52% of the residents and 62% of relatives who felt there was good communication and felt well informed. The service has reviewed the activities team and programme as a corrective action, and progress is discussed at the residents' meetings.</p> <p>There is a health and safety and risk management programme in place including policies to guide practice that is generated from the national health and safety committee. The service has a health and safety officer (interviewed) who is the activities assistant, with health and safety level 1 qualifications. The health and safety committee review incidents/accidents/hazards and near misses and provide a report to the quality improvement meeting. Staff interviewed confirmed they are informed when health and safety</p>
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		<p>meetings are due and can provide input into health and safety. Each month there is a focus on one of the golden rules of safety. All staff and contractors receive a health and safety induction. The hazard register has been updated in March 2019.</p> <p>Falls prevention strategies are in place that includes 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>	FA	<p>Incident and accident data has been collected and analysed. Fifteen electronic resident-related incident reports for February 2020 were reviewed including four unwitnessed falls, two stage 1 pressure injuries, one challenging behaviour, five skin tear/bruise and three witnessed falls. All reports and corresponding resident files reviewed evidenced that appropriate clinical care has been provided following an incident and the relative had been notified. The incident reporting policy includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Pain assessments were completed post-falls and where appropriate for all other incidents. Unwitnessed falls had neurological observations completed and reviewed by an RN, and opportunities to minimise risks were identified. Data is linked to the organisation's benchmarking programme and used for comparative purposes.</p> <p>Discussions with the village manager, care centre manager and regional quality manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Section 31 notifications have been completed for the HDC complaint via the coroner, an instance of theft and the 2019 outbreak.</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>	FA	<p>There are human resources policies to support recruitment practices. A list of RN and allied health practising certificates is maintained. Eight staff files (one care centre manager, two RNs, four caregivers, one diversional therapist) were reviewed and all had relevant documentation relating to employment. Performance appraisals had been completed annually. The service has an orientation programme in place for each role 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 adequately orientated to the service. Caregivers are level two of Careerforce once they have completed their orientation booklet.</p> <p>There is an annual education plan that is outlined on the 'clinical audit, training and compliance calendar'. The plan has been completed for 2019 and commenced for 2020. There are good attendance numbers and staff who do not attend are required to read the education material and sign the reading sheet. The training programme is flexible enough to add additional in-services relevant to the service. Ongoing education sessions include (but are not limited to); palliative care, recognising decline of the frail person, falls minimisation, pain assessment and management. All compulsory sessions are held according to</p>

		<p>schedule. External education is also provided. There are six of nine RNs including the CNL who have completed interRAI training.</p> <p>A competency programme is in place with different requirements according to work type (eg, caregivers, registered nurse and kitchen). Core competencies are completed, and a record of completion is maintained on staff files and online. The contracted physiotherapist completes safe manual handling and hoist training for staff.</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). The clinical nurse lead (CNL) works 40 hours from Tuesday to Saturday. The care centre manager and the CNL share on call for any emergency issues or clinical support.</p> <p>Two RNs including the CNL are rostered across all seven days, all shifts. A third RN or EN is rostered on the days the GP visits. On the afternoon shifts, a third RN or EN is rostered who work alongside the caregivers from 3 pm to 8 pm then attend to medication rounds. Each RN has a day a week for documentation.</p> <p>On the morning shift in the care centre there are five caregivers rostered; 3x 7 am to 3 pm, 2x 7 am to 1.30 pm. on Tuesday, Wednesday and Thursday, one caregiver is rostered from 8 am to 1 pm as a caregiver, then is a physiotherapy assistant from 1 pm. They are supported by a care team housekeeper from 8 am to 12 pm, this person tidies rooms and makes beds.</p> <p>There are four caregivers rostered on the afternoon shift; 2x 3 pm to 11 pm, 1x 4 pm to 9.30 pm, and 1x 5 pm to 11 pm. They are supported by a care team housekeeper from 5.30 pm to 8.30 pm, this person tidies lounges, serves supper and puts the dishes into the kitchen.</p> <p>There are two caregivers overnight from 11 pm to 7 am.</p> <p>The serviced apartments have one caregiver rostered from 7 am to 3 pm, 3 pm to 11 pm and 11 pm to 7 am. The care centre staff relieve this caregiver for breaks.</p> <p>Activities are provided from 9.30 am to 6.30 pm Monday to Thursday, and 9.30 am to 4.30 pm Friday, Saturday and Sunday.</p> <p>Staffing levels and skills mix policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery. Relatives and residents confirmed there were sufficient staff on duty.</p>
<p>Standard 1.2.9: Consumer Information Management</p>	FA	<p>The resident files were appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual electronic record. Personal</p>

<p>Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>		<p>resident information is kept confidential and cannot be viewed by other residents or members of the public. Electronic resident files are password protected from unauthorised access. Individual resident files demonstrated service integration.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>All enquiries are screened by the care centre and the village managers to ensure the service is able to provide for the specific needs of the resident and the level of care required. Prior to entry all residents have undergone a needs assessment that identifies the resident's level of care. Two of the family/whānau and residents interviewed indicated that at the time of admission the admission agreement was discussed.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>There are documented policies and procedures to ensure exit, discharge of residents would occur in a safe and timely manner. Planned exits, discharges or transfers are coordinated with the resident, family/whānau to ensure continuity of care. Copies of documentation are saved in the correspondence area of the resident's electronic file.</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>	<p>FA</p>	<p>There are medicine management policies and procedures that align with recognised standards and guidelines for safe medicine management practice. The service has an electronic resident file which includes the electronic medication system. All hospital and rest home residents including those in the care service apartments are entered onto the electronic medication system. All medications were stored securely in the locked medication room. The medication room had adequate safe storage and was at the correct temperature – less than 25 degrees Celsius. The medication fridges were monitored weekly. Original labels were present on medication in the medication trolley and cupboards. Medications such as eye drops and creams are dated on opening.</p> <p>Medication is administered by RNs and senior caregivers, and annual competencies are completed by staff who administer medications. When interviewed RNs and caregivers understood their medication administration role. The RNs, enrolled nurse and senior caregivers are responsible for the administration of medications and have completed medication competencies and annual medication education. The RNs have completed syringe driver training. All medications and robotic rolls were evidenced to be checked on</p>

		<p>delivery with any discrepancies fed back to the supplying pharmacy. Standing orders are not used.</p> <p>All fourteen (eight hospital and six rest home including three from the serviced apartments) electronic medication charts reviewed were charted and signed by the GP. Each of the charts were reviewed three monthly, photo identification and allergies were documented. All 'as required' PRN medications had indications for use identified and were correctly prescribed and administered as directed.</p> <p>There was one resident who self-medicates, a self-medicating competency was in place, reviewed and signed by the GP three monthly. The competency was scanned to the electronic file. The medications were stored securely in the residents' room.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The food control plan is current and expires in September 2020. The kitchen has a qualified chef who has worked in the service since it opened, kitchenhands support these roles. All staff have appropriate training and food handling qualifications.</p> <p>Residents have a nutritional assessment which forms the basis of the long-term care plan. Residents are encouraged to express their likes and dislikes and this information is provided to the kitchen. There is a whiteboard where individual requirements are recorded so the information is accessible for all staff. Special diets and individual requirements are catered for in the kitchen.</p> <p>The menu is planned by a dietitian over four 12-week rotations. The dietitian is available for residents' assessments as required.</p> <p>The kitchen is spacious and clean and all the food was stored appropriately off the floor and dated correctly. There is food safety information available on a noticeboard, the food control plan and kitchen manual with relevant policies and procedures available in the kitchen. Fridge and food temperature monitoring occurs as required.</p> <p>Food temperatures are checked when the food leaves the kitchen and when it is served. Food is transported to the care centre to be served. The chef serves the meals in the care centre at lunch and dinner which means she knows what the residents' preferences are.</p> <p>Chemicals were appropriately labelled and stored with emergency management information available.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the</p>	FA	<p>The service records the reason for declining service entry to potential residents should this occur and communicates this decision to the potential residents/family/whānau and the referring agency. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency for appropriate</p>

immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.		placement and advice.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	The seven files that were reviewed have care needs level assessments completed by the Needs Assessment Coordination (NASC) service prior to admission. InterRAI assessments were completed for five of the seven files (two did not require them as they were respite and palliative) and this assessment was completed six monthly or when there was a change in the resident's condition. Pain assessments are routinely completed post falls and wound cares. One of the files was for a resident on ACC funding and did not require an interRAI assessment; however, an interRAI assessment had been completed and reassessments were completed six monthly since 2018. Further to the interRAI assessment there are clinical risk assessments done at admission, six monthly and when there is a change in the resident's condition for (but not limited to) pain, skin integrity, continence and falls.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The four long-term files reviewed had long-term care plans with interventions outlining the residents' needs. Three residents had other types of funding, one was respite, one palliative care and one ACC. The long-term care plan for the resident receiving palliative care was yet to be completed as they had not been in the facility for 21 days. The resident with a respite care agreement had a short-term care plan in place to guide staff. The information from the risk assessments are included in the interventions, any resident scoring a medium risk of pressure injuries or who have developed a stage 1 pressure injury has a pressure relieving mattress in place. This was a new initiative as a result of the HDC complaint. Short-term care plans were in place and used when the resident's health status changes. Short-term care plans were reviewed regularly and are signed off as the goal is resolved or it becomes part of the long-term care plan. There is evidence of service integration in the resident's files with treatment plans by the physiotherapist and the dietitian as well as referrals to the Palliative Care Nurse Practitioner (NP).
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed	FA	Electronic care plans are updated by the RN in response to a change in a resident's health status/condition, a three-monthly review or other review by GP, NP or other health professional. RNs interviewed could describe how they access specialist support for continence and wound management when necessary. The sample of care plans confirmed the residents supports and needs are being met. The electronic resident file provides assessment, records progress, and also has the management plan for

<p>needs and desired outcomes.</p>		<p>wounds and the evaluations of wounds. Monitoring forms are utilised with residents who have identified needs in these areas, these include (but are not limited to) pain, food, fluid, restraint, vital signs, monthly weighs.</p> <p>There is a wound summary folder where information regarding each wound is kept, enabling the CNL and RNs to have a better overview of the total number and frequency of dressings required each day. There were five hospital and eight rest home residents with wounds. One hospital resident has three chronic wounds and has external wound specialist input from the district health board wound specialist. These were the service's only chronic wounds. The remaining wounds were two stage 1 sacral pressure injuries, two superficial skin tears and one skin lesion. Rest home residents' wounds included three superficial skin tears, one with an old bruise that has become a wound, one with incontinence associated dermatitis and two skin lesions. Pressure relieving equipment was in place for residents with pressure injuries and residents who have been identified as at risk of developing a pressure injury.</p> <p>There are adequate supplies available for wound care and continence with specialist advice from the SDHB specialist staff as required</p> <p>Residents and family/whānau interviewed were satisfied their needs are being satisfactorily met.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>There are two permanently employed activities staff. One is a diversional therapist trained more than 20 years ago and is currently undertaking the Diversional Therapy Careerforce programme and the other (a recreational therapist) is planning to commence the Careerforce training this year. Each staff member has a current first aid certificate.</p> <p>These staff work a four on four off roster over seven days and provide a programme for both rest home and hospital residents. There is also a regular volunteer who was a former recreational therapist and now works as a volunteer. This provides a "third pair of hands" who knows the residents well and can assist in such activities as van trips/outings. There is a monthly planner which provides information regarding available activities which include (but are not limited to) movement to music, themed craft activities, newspaper reading which provides opportunity for reminisce. The programme is flexible when spontaneous events of interest occur.</p> <p>There is a van with a wheelchair space. New guidelines for taking residents out have been developed with a ratio of two staff to two mobile residents and one wheelchair resident. Evaluations from these activities indicate satisfaction from residents. There is also a non-mobile outing where residents do not get out of the van and they visit local points of interest and history.</p> <p>The service is reviewing the activities programme to be more resident focussed with the interests of the residents driving the programme. Residents are encouraged to maintain previous interests and community links. If they are no longer able to independently do this the staff will work hard to assist this to occur with</p>

		<p>examples given. The apartment residents provide support to the care facility residents by undertaking activities such as entertainment afternoons and there are a number of shared activities for residents from the care facility and the apartments.</p> <p>Residents and family's interviews expressed satisfaction with the activities provided and the staff involved.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The initial and long-term care plans sampled evidenced evaluations within appropriate timeframes; 21 days for the initial and six monthly or earlier depending on the resident for long term. The short-term care plans reviewed had also been evaluated by the RN.</p> <p>Family/whānau and resident input is evident in the care plans with them having opportunity to be attend or provide input to the six-monthly MDT meeting. The utilisation of the MDT approach is demonstrated in the evaluation of care plans with feedback from GPs, physiotherapist and NP.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>There is evidence of referral and associated documentation to other health and disability services in the resident files that were reviewed. Residents/EPOAs were involved and informed of the referral and the associated processes.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>There are documented processes for the management of waste and hazardous substances to ensure incidents are reported in a timely manner. Staff have adequate amounts of personal protective equipment in areas for use. The maintenance staff uniform includes a "hi viz" vest.</p> <p>Chemicals were stored safely throughout the facility. Material safety data sheets were readily accessible for staff. Chemical safety training has been completed by relevant staff.</p>

<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The full-time maintenance person is on-call outside of business hours. This role supervises the property and gardening staff and receives works orders from Summerset's head office which provide the annual routine maintenance plan. The routine maintenance plan has monthly schedules which include (but not limited to) testing and tagging of equipment, equipment checks and calibration of equipment (kitchen and medical equipment), windows, boiler checks. Hot water temperatures have been tested and recorded monthly with readings maintained less than 45 degrees Celsius. Reactive maintenance requests are sent in response to any issues that arise. There are preferred contractors who are available 24/7.</p> <p>There is adequate equipment available for staff to provide for the residents' needs.</p> <p>There are three levels, serviced apartments on the ground floor – these are all certified for rest home care, care centre on the first floor and independent apartments on the second level. The building is spacious, with corridors wide enough for residents/visitors to easily pass. The external areas are well maintained with safe access to all communal areas and outdoor areas. The outdoor balcony has seating and shade.</p> <p>The building warrant of fitness expires on 5 May 2020.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>Visual inspection evidenced toilet and shower facilities are of an appropriate design to meet the needs of the residents. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. Thirty-seven resident rooms have an ensuite and six other rooms have a shared ensuite. The palliative care room ensuite is large with enough room to use a shower trolley if required. There are adequate numbers of communal toilets located near the communal areas. Communal toilet/shower facilities have a system that indicates if it is engaged or vacant.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Resident rooms have been personalised and are warm and spacious. Staff interviewed reported there is more than adequate space to use equipment required to provide care to residents.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment,</p>	FA	<p>There are a number of communal areas throughout the facility including lounges (large and small) and a spacious library. On the day of the audit there was a music group in the library. Activities as observed on</p>

<p>Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>		<p>the day of the audit are held in the lounges. The lounges are large enough so there is no impact on other residents and visitors who are not involved in activities. Smaller lounges and family rooms are equipped with a kitchenette for residents and visitors to sit and make a cup of tea/coffee or for a smaller activity group. The dining rooms are spacious, and residents can see the chef serve the meals which has come from the kitchen.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>When interviewed, cleaning and laundry staff demonstrated a sound understanding of infection prevention and control strategies. Regular training is provided for staff by the chemical supplier. Both internal and external audits (undertaken by the chemical supplier) monitor the effectiveness of laundry and cleaning processes. There is adequate personal protective equipment available for staff to use in the laundry and when cleaning.</p> <p>Trolleys used by cleaners are locked in a cupboard when they are not in use.</p> <p>All resident linen and personal clothing are laundered on site. The laundry is located in the basement, there are chutes for the delivery of dirty laundry. The laundry is well equipped with defined clean/dirty areas. The machinery has been serviced regularly. There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services.</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>	<p>FA</p>	<p>There are emergency and civil defence plans to guide staff in managing emergencies and disasters. Summerset at Bishopscourt has an approved fire evacuation plan and fire drills occur six-monthly. There are electric and gas cooking facilities with barbeques available in the event of a power failure. In the event of an emergency there are adequate food and water supplies. The service has civil defence and emergency plans in place to guide staff in managing emergencies and disasters. There are adequate civil defence supplies including equipment, food and water storage for three litres per person per day for seven days. Civil defence supplies are checked regularly. There are barbeques and gas bottles for alternative cooking. A generator is available as required and there is battery backup for call bells and lights. Call bells were evident in residents' rooms, lounge areas and toilets/bathrooms. Staff carry walkie-talkies and one staff member with first aid responds to village call outs, there is at least one rostered staff member on each shift with a current first aid certificate. The mandatory in-service programme for all staff includes emergencies, first aid and cardiopulmonary resuscitation.</p> <p>Call bells are in residents' rooms, lounge areas and toilets/bathrooms. There are adequate numbers of communal/visitors' toilets with security/privacy locks in place. The facility is secured at night. The village gates are locked at night with access to the emergency services.</p>

<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>The building is heated by a gas boiler which maintains all areas at a safe and comfortable temperature. The resident rooms and communal areas have adequate light and ventilation.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>The infection control programme is appropriate for the size and complexity of the service. There is an infection control responsibility policy that includes responsibilities for the infection control officer (RN), who was awarded the Summerset nurse of the year award for 2019. The infection control officer has a signed job description. The infection control programme is linked into the quality management system and reviewed annually by the infection control quality manager at head office, in consultation with infection control officers. The focus for 2020 is to decrease the infection rates for eye infections, respiratory infections and urine infections. There is a monthly “zoom” meeting with the infection control quality manager and all infection control officers. Facility meetings include a discussion of infection control matters.</p> <p>Visitors are asked not to visit if they are unwell. Influenza vaccines are offered to residents and staff. Hand sanitisers are available throughout the facility. There was one outbreak since the previous audit.</p> <p>Extra precautions were in place due to COVID-19 including a form for all visitors and contractors to complete regarding their present health status, posters and extra hand gels were available throughout the facility, visitors were restricted, and head office were contacting relatives to update them of current precautions and restrictions. A good supply of personal protective equipment (PPE) was sighted. A pandemic plan is in place.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the</p>	<p>FA</p>	<p>The infection control officer has been in the role for one year and has attended infection control training. Extra training has been provided for resident-specific cases of hepatitis, and pseudomonas infections. The monthly “zoom” meetings with all Summerset infection control officers includes topical infection control.</p> <p>The infection control team comprises of a cross section of staff from areas of the service. The infection control team meet monthly prior to the RN meeting and provide a report to the quality improvement meeting, facility meetings and infection control quality manager at head office.</p> <p>The infection control officer has access to an infection control nurse specialist at the DHB, GPs, laboratory,</p>

organisation.		pharmacy and expertise within the organisation.
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>Policies and procedures are developed and reviewed at head office. Policies are available to all staff. They are notified of any new/reviewed policies and are required to read and sign for these.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control officer is responsible for coordinating and providing education and training to staff. The induction package includes specific training around handwashing competencies and standard precautions. Ongoing training occurs annually as part of the training calendar set at head office. Education for 2019 included sepsis, hand hygiene, outbreak management, wound management and signs, symptoms and management of urine infections, management of eye infections, and resident-specific training occurred as required. Resident education occurs as part of providing daily cares. Care plans can include ways to assist staff in ensuring this occurs.</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 procedure, process for detection of infection, infections under surveillance, outbreaks and quality and risk management. Infection events are collected monthly and entered into the electronic system. The infection control officer provides infection control data, trends and relevant information to the infection control committee and clinical/quality meetings. Areas for improvement are identified, corrective actions developed and followed up. The facility is benchmarked against other Summerset facilities of similar size and benchmarking results are fed back to the infection control officer and used to identify areas for improvement. Infection control audits across all services are completed and corrective actions are signed off (sighted). Surveillance results are used to identify infection control activities and education needs within the facility. Reports and graphs are displayed on the</p>

		<p>staffroom infection control noticeboard.</p> <p>There has been one respiratory outbreak in 2019, which was well documented, timely notifications were made, good communication was maintained, documented and discussed at relevant meetings.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service has policies and procedures to support of the use of enablers and restraints. The policy meets the intent of the restraint minimisation standards. The CNL is the restraint officer and has a job description which defines the responsibility of the role. There are seven hospital level residents with restraint (bedrails) and one hospital resident with an enabler (bedrails) on the day of audit. Voluntary consent and assessment for the resident with an enabler were up to date. The enabler is reviewed as part of the monthly clinical meetings. Risks associated with the use of the enabler has been identified in the care plan and monitoring has occurred at the documented frequency. Restraint minimisation, enabler training and challenging behaviour was completed in May and June 2019.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>The role and responsibility for the restraint coordinator is included in the restraint policy. Registered nurses complete a restraint self-learning package on orientation and ongoing education is included in the education planner. Care staff also complete self-learning packages. The restraint committee (care centre manager, clinical nurse leader and the registered nurses) approve the use of restraints. The restraint minimisation and enabler policy clearly describe responsibilities for staff.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>The restraint coordinator undertakes restraint assessments in consultation with the RNs, GP and in partnership with the family/whānau. Restraint assessments are based on information in the care plan, resident discussions and on observations of the staff. There is a restraint assessment tool available, which is completed for residents requiring an approved restraint for safety. Assessments reviewed for three residents on restraint and one resident with an enabler were reviewed and all were completed as required and to the level of detail required for the individual residents. Completed assessments considered those factors listed in 2.2.2.1 (a) - (h), and the risks identified were documented in the care plans for all seven residents on restraint and one resident with an enabler.</p>

<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. Monitoring and observation is included in the restraint policy. There are approved restraints documented in the policy. The restraint coordinator is responsible for ensuring all restraint documentation is completed. The approval process includes ensuring the environment is appropriate and safe. Restraint authorisation is in consultation/partnership with the resident (as appropriate) or whānau/EPOA, GP and the facility restraint coordinator. The risks identified were documented in the care plans for residents on restraint and the resident with an enabler. The frequency of monitoring was documented in the care plans, monitoring forms reviewed were consistently completed in line with the care plan.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations occur three monthly as part of the ongoing reassessment for the resident on the restraint register, and as part of the care plan and GP review.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>Policies are reviewed by the policy review group at head office. Restraint use in the facility is evaluated in the monthly RN team meeting and annually. The restraint coordinator provides monthly restraint and enabler reports to the regional manager. Internal restraint audits identify any areas for improvement. Restraint is discussed at clinical meetings and at handovers. There have been no incidents relating to restraint use.</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.

No data to display

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	CI	The benchmarking data in 2018 and 2019 were analysed and noted to be above average. What was concerning was that both the rest home and hospital residents' falls were increasing, with rest home falls around 6/1,000 bed nights in April 2018, and 5/1,000 bed nights in April 2019. Hospital falls were 6/1,000 bed nights in April 2018 and 10/1,000 bed nights in 2019.	<p>An initiative was put in place which included continuing to trend and analyse monthly data, changing of staff hours, purchasing of more equipment, dedicating staff to residents requiring rehabilitation, and improving the activities programme.</p> <p>The physiotherapist visits the facility for two hours a day across Mondays and Thursdays. A physiotherapist assistant role was created where one caregiver works half shift caregiver and half shift as physiotherapist assistant. This role includes exercises with residents, with regular oversight and monitoring of progress by the physiotherapist. The staff were educated on falls minimisation, manual handling, minimising the use of restraints, challenging behaviour management, signs and symptoms of urine infections, dementia and delirium, and dehydration throughout 2019.</p> <p>The care team housekeeping role especially in the evenings while tidying the lounges etc, allows for extra monitoring of the residents. The caregivers interviewed were knowledgeable on falls minimisation techniques and could describe an array of strategies they use to</p>

			<p>minimise falls. The caregivers interviewed reported they are currently focusing on ensuring residents have adequate food and fluid intake and detecting early changes noted in resident condition which may prevent a fall.</p> <p>The data for January and February 2020 shows the falls rate for both rest home and hospital residents have fallen to 2/1,000 bed nights.</p>
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End of the report.