# Summerset Care Limited - Summerset at Heritage Park

## 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:

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| **Legal entity:** | Summerset Care Limited |
| **Premises audited:** | Summerset at Heritage Park |
| **Services audited:** | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) |
| **Dates of audit:** | Start date: 26 February 2020 End date: 26 February 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:** 60

# 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 |
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| | 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 |
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| | 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 Heritage Park provides rest home and hospital (medical and geriatric) level care for up to 58 residents in the care centre and up to 20 residents at rest home level care across the serviced apartments. On the day of the audit there were 60 residents including three rest home residents in serviced apartments.

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

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

The previous audit shortfall around interventions remains an area for improvement.

## Consumer rights

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| 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. |

Information about the Code and related services is readily available to residents and families. Complaints processes are being implemented and complaints and concerns are managed and documented. Residents and relative interviewed confirmed they are kept informed on health matters. There are regular resident/relative meetings and newsletters.

## Organisational management

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| 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. |

Summerset at Heritage Park implements a quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to include monthly quality improvement meetings. Surveys and monthly 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 of 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

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| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. | | Some standards applicable to this service partially attained and of low risk. |

Registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family input. Care plans viewed demonstrate service integration and are reviewed at least six-monthly. Resident files include medical notes by the contracted general practitioners and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses are responsible for the administration of medicines.  Medication charts are reviewed three-monthly by the GP.

The diversional therapist implements the activity programme to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations.

All meals are cooked on site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated.

Residents commented positively on the meals.

## Safe and appropriate environment

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| 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 holds a certificate of occupation. There is a preventative and reactive maintenance programme. All equipment has been tested and tagged.

## Restraint minimisation and safe practice

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. | | Standards applicable to this service fully attained. |

Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort. Staff receive regular education and training on restraint minimisation. At the time of the audit there was one hospital resident using an enabler and one hospital resident requiring the use of a restraint.

## Infection prevention and control

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| 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 coordinator collates infection events and uses the information obtained through monthly surveillance to determine infection control activities, resources and education needs within the facility. The service engages in benchmarking with other Summerset facilities.

## Summary of attainment

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

| Attainment Rating | Continuous Improvement (CI) | Fully Attained (FA) | Partially Attained Negligible Risk (PA Negligible) | Partially Attained Low Risk (PA Low) | Partially Attained Moderate Risk (PA Moderate) | Partially Attained High Risk (PA High) | Partially Attained Critical Risk (PA Critical) |
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| **Standards** | 0 | 15 | 0 | 1 | 0 | 0 | 0 |
| **Criteria** | 0 | 40 | 0 | 1 | 0 | 0 | 0 |

| Attainment Rating | Unattained Negligible Risk (UA Negligible) | Unattained Low Risk (UA Low) | Unattained Moderate Risk (UA Moderate) | Unattained High Risk (UA High) | Unattained Critical Risk (UA Critical) |
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| **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 |
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| Standard 1.1.13: Complaints Management<br><br>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 complaint register that includes relevant information regarding the complaint. Complaints/concerns are discussed at the relevant meetings. There have been six care centre complaints since the last audit (four verbal and two written). The complaints reviewed included follow-up meetings, investigations and letters offering independent advocacy. The HDC timeframes for complaints management had been met. |
| Standard 1.1.9: Communication<br><br>Service providers communicate effectively with consumers and provide an environment | FA | Five residents (three rest hone and two hospital) and one family member (hospital relative) stated they were welcomed on entry and were given time and explanation about services and procedures. The relative interviewed also stated they are informed of changes in the health status of the residents. Twelve incidents/accidents (across December 2019 and January 2020) reviewed, evidenced the family are notified of incidents/accidents. Resident/relative meetings are held monthly and a newsletter is available to residents/relatives. Survey results have been fed back to residents/relatives. The meeting minutes are available in the library. The acting village manager and the care centre manager have an open-door policy. An independent advocate visits the residents monthly.<br><br>The service has policies and procedures available for access to interpreter services for residents (and their |

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| conducive to effective communication. | | family/whānau). |
| Standard 1.2.1: Governance<br>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Summerset at Heritage Park is part of the Summerset group of villages. The service provides care for up to 78 residents. There are 58 dual-purpose beds in the care centre on level one and 20 serviced apartments across the ground floor and second floor certified to provide rest home level care. On the day of the audit, there were 60 residents in total, 29 residents at rest home level (including three in the serviced apartments, one resident under ACC and one resident from the village under complimentary respite care) and 31 residents at hospital level (including one younger person and one resident under ACC).<br>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 Heritage Park has a site-specific business plan and quality management plan for 2020. Goals are developed in consultation with the village manager, care centre manager and regional operations manager. The quality management plan is reviewed quarterly throughout the year. The 2019 business plan and goals had been reviewed.<br>There is currently an acting village manager at Summerset at Heritage Park for the past two months who has a diploma in business management (2016) and a certificate in business management (2017). A village manager (non-clinical) has been appointed to commence in the near future. A HealthCERT notification for change of manager was sighted.<br>The care centre manager (RN) has been in the role one year and four months and has previous aged care experience in clinical management. Village managers and care centre managers attend annual organisational forums. The care centre manager attends clinical education and the DHB forums. |
| Standard 1.2.3: Quality And Risk Management Systems<br>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement | FA | Summerset at Heritage Park is implementing the organisation's 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. Policies are reviewed on a regular basis and staff are made aware of the changes. The Summerset group has a 'clinical audit, training and compliance' calendar. The calendar schedules the training and audit requirements for the month. The care centre manager completes a monthly report confirming completion of requirements and outcomes. The report is discussed at the quality meetings and to the regional quality manager who visits the site fortnightly.<br>The annual residents/relatives survey is completed in May each year. There has been an improvement in activities and care services. Action plans included integration of all residents for social activities including village residents, serviced apartment residents and care centre residents. An administrator has been appointed to the care centre who is the first contact person for visitors to the care centre which has improved the communication channels. The |

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| principles. | | overall result for Summerset 2019 was 96.4 with Heritage at the Park overall result at 96.3. Results of surveys are discussed at staff meetings.<br><br>There is a meeting schedule including (but not limited to) weekly management meetings, monthly quality improvement, all staff meetings, caregiver and registered nurse meetings. Meeting minutes evidenced discussion about clinical indicators (eg, incident trends, infection rates), audit outcomes and quality improvements. Health and safety, infection control and restraint meetings occur monthly. Meeting minutes and data (analysis and graphs) are available to all staff in a reading folder.<br><br>The service is implementing an internal audit programme that includes aspects of clinical care, environment, health and safety, infection control and non-clinical services. Issues arising from internal audits are developed into corrective action plans. Monthly and annual analysis of results is completed and provided across the organisation.<br><br>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. Summersets regional quality manager analyses data collected via the monthly reports and corrective actions are required based on benchmarking outcomes.<br><br>There is a health and safety and risk management programme in place including policies to guide practice. One health and safety officer and one health and safety representative (interviewed) had completed health and safety training. The health and safety committee are representative of all services and meet monthly. Staff have the opportunity to raise any health and safety concerns with representatives which are discussed at the committee meeting and feedback to staff. Each month there is a health and safety “golden rule” and staff are provided with resources and education about the rule. Staff accidents/incidents and hazard reports are entered into the RMSS which alerts the village manager and clinical manager. The health and safety representative’s complete health and safety induction for new employees. The health and safety manager from head office completed an internal audit in November 2019 with all corrective actions signed off. There is a current hazard register.<br><br>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 physiotherapist is involved in resident assessments and post falls assessment. Staff receive safe manual handling training by the physiotherapist. |
| Standard 1.2.4: Adverse Event Reporting<br><br>All adverse, unplanned, or untoward events are systematically | FA | Incident and accident data have been collected and analysed monthly and annually. Twelve resident related incident reports across December 2019 and January 2020 were reviewed. All reports and corresponding resident files reviewed evidenced that appropriate and timely assessment and clinical care had been provided following an incident. 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. Discussion with the acting village manager and care centre manager confirmed that there is an awareness of the requirement to notify relevant authorities in |

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| recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | | relation to essential notifications. There have been no Section 31 notifications required. |
| Standard 1.2.7: Human Resource Management<br><br>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | There are human resources policies to support recruitment practices. A register of practising certificates is maintained for registered nurse, GPs and allied health professionals involved with the service. Five staff files (one care centre manager, one RN, one diversional therapist and two caregivers) were reviewed. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Annual performance appraisals had been completed at three weeks post-employment and annually thereafter.<br><br>There is an annual education plan that is outlined on the 'clinical audit, training and compliance calendar'. The 2019 training plan has been completed and the 2020 training schedule has commenced. In-service is incorporated into the staff meetings. Repeat sessions are offered for staff who have not been able to attend the staff meeting. Records of individual attendance is maintained. A competency programme is in place with different requirements according to work type (eg, caregivers, RN and household staff). Core competencies are completed, and a record of completion is maintained on staff files.<br>The DT is a Careerforce assessor and the learning and development manager at head office is a Careerforce assessor. There are 12 registered nurses (RN) with one RN interRAI trained. There are two RNs registered to complete interRAI training. |
| Standard 1.2.8: Service Provider Availability<br><br>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | 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. The clinical nurse leader works full time Sunday to Thursday. Staffing has been stable for the last year. Caregivers interviewed confirmed that staff are replaced when off sick. The roster identified staff were replaced when sick with the occasional use of agency staff.<br><br>In the care centre, there are two RNs on the morning, afternoon and night shifts. There is an additional RN on the CNL days off and for days when there is a GP round. They are supported by eight caregivers on morning shifts (five full shift and three short shifts with staggered finishing times), eight caregivers on the afternoon shifts (four full shift and four short shifts with staggered finishing times). There are two RNs and one caregiver on the night shift.<br><br>There is a caregiver on morning, afternoon and night shift in the serviced apartments. One RN on duty provides oversight to the rest home residents in the serviced apartments. |

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| | | Staff carry pagers that alert them to call bells and walkie talkies, so they can communicate effectively.<br><br>A staffing levels and skills mix policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery. Interviews with residents and relative confirmed that staffing levels are sufficient to meet the needs of residents. |
| Standard 1.3.12: Medicine Management<br><br>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | There are policies and procedures in place for all aspects of medication management, including self-administration. There was one resident self-administering on the day of audit. A consent form had been signed and the resident deemed competent to self-administer. The inhaler was in the resident's drawer. There were no standing orders. There were no vaccines stored on site.<br><br>The facility uses an electronic and robotic pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. RNs administer all medications. Staff attend annual education and have an annual medication competency completed. All RNs are syringe driver trained by the hospice. The medication fridge and room temperatures are checked weekly. Eye drops are dated once opened.<br><br>Staff sign for the administration of medications on the electronic system. Ten medication charts were reviewed (six hospital and four rest home). Medications are reviewed at least three monthly by the GP. There was photo ID and allergy status recorded. 'As required' medications had indications for use charted. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management<br><br>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The facility uses a contracted catering service. There is a head chef who works Tuesday to Saturday and two other cooks, one who works Sunday to Saturday and the other who works Friday to Thursday. There are two kitchenhands who cover the week between them. All cooks have current food safety certificates. The head chef oversees the procurement of the food and management of the kitchen. There is a well-equipped kitchen and all meals are cooked on site. Meals are served in all areas from scan boxes. The temperature of the food is checked before serving. Special equipment such as lipped plates is available. On the day of audit meals were observed to be hot and well presented. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Some are now computer based but others are still paper-based. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures were monitored and recorded weekly. Food temperatures are checked and these were all within safe limits. The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes were noted. The twelve weekly menu cycle is approved by a dietitian. There is a separate vegetarian menu. The chef fortifies food for specific residents if requested by the dietitian. All resident/families interviewed were satisfied with the meals.<br><br>The food control plan was certified on 30 October 2018. |

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| Standard 1.3.6: Service Delivery/Interventions<br><br>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Low | When a resident's condition changes the RN initiates a GP consultation. Staff stated that they notify family members about any changes in their relative's health status. All care plans reviewed had interventions documented to meet the needs of the resident, however the risks associated with restraint and enabler were not included in the care plans for two residents. There is documented evidence of care plans being updated as residents' needs changed.<br><br>Resident falls are reported on the electronic register and written in the progress notes. Neurological observations are taken when there is a head 'knock' or for an unwitnessed fall.<br><br>Care staff interviewed stated there are adequate clinical supplies and equipment provided including continence and wound care supplies.<br><br>Wound assessment, wound management and wound evaluation forms are in place for all wounds. Wound monitoring occurs as planned. There are currently no pressure injuries. High risk pressure injury residents have pressure injury prevention strategies documented in their care plans, however not all turning charts had been implemented as per care plans.<br><br>Electronic monitoring forms are in use as applicable such as weight, vital signs, repositioning and wounds. Behaviour charts are available for any residents that exhibit challenging behaviours. |
| Standard 1.3.7: Planned Activities<br><br>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. | FA | There is one diversional therapist who works forty hours a week and one recreational therapist who works Fridays and weekends plus one hour a day during the week. The recreational therapist is currently completing the diversional therapy course. They also have a group of volunteers involved in the service. On the day of audit residents were observed going for a walk, participating in a yoga session, playing mini golf and rummikub.<br><br>There is a monthly programme in large print on noticeboards in all areas plus a weekly newsletter. Every month each resident is given a copy of the monthly programme and each week a newsletter to keep in their room. Residents have the choice of a variety of activities in which to participate and every effort is made to ensure activities are meaningful and tailored to residents' needs.<br><br>Those residents who prefer to stay in their room or who need individual attention have one on one visits to check if there is anything they need and to have a chat. The DT stated that volunteers are willing to do this.<br><br>There is a weekly interdenominational church service and weekly Catholic communion.<br><br>There is a van outing every Friday. The van driver and the van assistant hold current first aid certificates. Special events like birthdays, Matariki, Easter, Mothers' Day, Anzac Day and the Melbourne Cup are celebrated. There is weekly entertainment. |

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| | | There is regular pet therapy and a farm show every three months.<br><br>There is community input from the local preschools, schools and choirs. Due to the severe disability of stroke residents, Stroke club come into the facility rather than residents going out. Volunteers bring in art works and hold exhibitions.<br><br>Residents go out to Café Musica (concert and lunch), bowling tournaments with other care facilities, the RSA and one resident goes to an outside gym.<br><br>The YPD resident enjoys more modern music and more advanced quizzes and these are supplied. The resident is also taken to the café or out to local malls for shopping and coffee on a regular basis.<br><br>Residents have an activity assessment completed over the first few weeks following admission that describes the residents past hobbies and present interests, career and family. Resident files reviewed identified that the comprehensive individual activity plan is based on this assessment. Activity plans are evaluated at least six monthly at the same time as the review of the long-term care plan.<br><br>Resident meetings are held three monthly. |
| Standard 1.3.8: Evaluation<br><br>Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Except for the complimentary respite resident all care plans reviewed had been evaluated by the registered nurse six monthly or when changes to care occurred. Short-term care plans for short-term needs are evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. Activities plans are in place for each of the residents and these are also evaluated six monthly. The multidisciplinary review involves the RN, GP and resident/family if they wish to attend. There is at least a three-monthly review by the GP. The family members interviewed confirmed that they are informed of any changes to the care plan. |
| Standard 1.4.2: Facility Specifications<br><br>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building holds a CPU dated 31 August 2017. The Council will issue a warrant of fitness when village construction is completed. There is currently no construction in the care centre. There is a full-time property manager who has three staff to assist him. Preventative and reactive maintenance occurs. Hot water temperatures are monitored. All equipment has been tested and tagged. |
| Standard 3.5: | FA | The infection control policy includes a surveillance policy, including a surveillance procedure, process for detection |

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| Surveillance<br><br>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | | of infection, infections under surveillance, outbreaks and quality and risk management. Infection events are collected monthly and entered onto the VCare electronic system. The infection control coordinator (RN) provides infection control data, trends and relevant information to the infection control committee. The monthly infection events, trends and analysis are reviewed by management and data is forwarded to head office for benchmarking. Areas for improvement are identified with corrective actions developed and followed up. Infection control audits are completed, and corrective actions are signed off (sighted). Surveillance results are used to identify infection control activities and education needs within the facility. There has been one confirmed norovirus outbreak in September 2018. Case logs and notification to Health Protection unit were sighted. |
| Standard 2.1.1: Restraint minimisation<br><br>Services demonstrate that the use of restraint is actively minimised. | FA | There are policies around restraints and enablers. There was one hospital resident requiring the use of a bedrail restraint and one hospital resident using a bedrail enabler at the time of audit. The resident using the enabler had voluntarily signed consent. Caregivers interviewed described interventions to minimise restraint use including checking that all residents' needs such as toileting and hydration needs are met. Staff receive training around restraint minimisation that includes annual competency assessments. |

# Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

| Criterion with desired outcome | Attainment Rating | Audit Evidence | Audit Finding | Corrective action required and timeframe for completion (days) |
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| Criterion 1.3.6.1<br>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Low | Electronic monitoring forms are in use and staff use these to document all monitoring required. Instructions for monitoring including repositioning are documented in the residents’ care plans, however not all turning charts had been implemented. | (i) Two of three high risk pressure injury resident files reviewed did not have two hourly repositioning documented on turning charts as per the care plans.<br>(ii) One resident with a restraint and one resident with an enabler dd not have the risks associated with the restraint/enabler use (as per the assessments) documented in the care plan. | (i) Ensure two hourly repositioning is documented on turning charts as per care plans and (ii) ensure risks of restraint and enabler use is identified on the care plan.<br>90 days |

# 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.

| No data to display |
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End of the report.