# Summerset Care Limited - Summerset in the Bay

## 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 BSI Group New Zealand Ltd, 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Summerset Care Limited

**Premises audited:** Summerset in the Bay

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

**Dates of audit:** Start date: 18 October 2021 End date: 19 October 2021

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 55

# Executive summary of the audit

## 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 |
|  | 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 in the Bay provides rest home and hospital level care for up to 50 residents in the care centre and up to 20 rest home residents in the serviced apartments. On the day of the audit there were 55 residents including six 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 a village manager who is appropriately qualified and is supported by an experienced regional quality manager (RQM) who is overseeing the care centre until the new care centre manager commences in the role. The residents and relative interviewed spoke positively about the care and support provided.

The previous audit shortfall around neurological observations has been addressed.

This audit identified a shortfall around complaints management.

## 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. |  | Some standards applicable to this service partially attained and of low risk. |

Information about the Code and related services is readily available to residents and families. Complaints processes are in place with complaints and concerns being 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 in the Bay has a documented quality and risk management system that supports the provision of clinical care. There are quality improvement meetings to discuss issues and corrective actions. 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. |  | Standards applicable to this service fully attained. |

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 demonstrated service integration and are reviewed at least six-monthly. Resident files include medical notes by the contracted general practitioner and visiting allied health professionals.

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

The recreational 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 current building warrant of fitness. 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 were six residents using an enabler and six residents 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.

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| **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 | 15 | 0 | 1 | 0 | 0 | 0 |
| **Criteria** | 0 | 40 | 0 | 1 | 0 | 0 | 0 |

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| **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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

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| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | PA Low | 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 sixteen care centre complaints since the last audit. The complaints reviewed included follow-up meetings, investigations and letters offering independent advocacy, however four of the sixteen were not acknowledged within five working days as per policy.  One complaint from the Health and Disability Commission was received six weeks prior to audit, and is currently being worked upon, and the HDC timeframes for complaints management had been met. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Five residents (one rest home and four hospital) and two family members (one hospital and one rest home relative) stated they were welcomed on entry and were given time and explanation about services and procedures. The relatives interviewed also stated they are informed of changes in the health status of the residents.  Ten incidents/accidents (across September 2021 and October 2021) reviewed, evidenced the family are notified of incidents/accidents. Resident/relative meetings are held bi-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 area. The village manager and the acting care centre manager (Regional Quality Manager) have an open-door policy. An independent advocate is available to visit the residents as required.  The service has policies and procedures available for access to interpreter services for residents (and their family/whānau).  Residents and families confirmed they received regular communication and updates regarding Covid-19 levels, restrictions, and associated infection control measures. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Summerset in the Bay is part of the Summerset group of villages. The service provides care for up to 50 residents at hospital (geriatric and medical) and rest home level care in the care centre. One resident room is designated as a day stay room and one for village residents requiring respite care. There are currently 20 serviced apartments certified for rest home level of care. On the day of the audit, there were 55 residents in total, 20 residents at rest home level (including six in the serviced apartments, and two residents under ACC) and 35 residents at hospital level (including one resident under an LTS-CHC contract).  The Summerset Group Limited Board of Directors have overall financial and governance responsibility and there is a company strategic business plan in place. Summerset in the Bay has a site-specific business plan and quality management plan for 2021. Goals are developed in consultation with the village manager, acting care centre manager and regional operations manager. The quality management plan is reviewed quarterly throughout the year. The 2020 business plan and goals had been reviewed.  The village manager at Summerset in the Bay has been in the role for 15 months and previously held other health management roles. The village manager has a Bachelors in Speech and Language Therapy, and a Master’s in Public Management.  The acting care centre manager (RQM) has been with Summerset for two years, and has extensive aged care experience in regional clinical and quality roles. A new care centre manager has been recruited and will commence orientation at the site on 8 November 2021. Village managers and care centre managers attend annual organisational forums. The managers are also supported by a clinical nurse leader who attends clinical education and the DHB forums. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | Summerset in the Bay 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 acting care centre manager completes a monthly report confirming completion of requirements and outcomes. The report is discussed at the quality meetings and would normally be shared with the regional quality manager on their regular site visits.  The annual residents/relatives survey is completed annually. The overall result for Summerset 2020 was 97.1 with Summerset in the Bay overall result at 95.9. Results of surveys are discussed at staff meetings.  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 (e.g., 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 the staffroom.  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 with these addressed in a timely manner. Monthly and annual analysis of results is completed and provided across the organisation.  There are monthly accident/incident benchmarking reports completed by the acting 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. The acting care centre manager in her regional quality manager role then analyses data collected via the monthly reports and corrective actions are required based on benchmarking outcomes.  There is a health and safety and risk management programme in place including policies to guide practice. The health and safety officer (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 risk management system which alerts the village manager and acting care centre manager. The health and safety representative’s complete health and safety induction for new employees. There is a current hazard register.  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 as part of the annual training and competency programme. |
| Standard 1.2.4: Adverse Event Reporting  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. | FA | Incident and accident data have been collected and analysed monthly and annually. Ten resident related incident reports across September 2021 and October 2021 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 village manager and acting care centre manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been Section 31 notifications submitted for the change of care centre manager, two absconding incidents, two stage three, and one stage four pressure injuries. |
| Standard 1.2.7: Human Resource Management  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 nurses, GPs and allied health professionals involved with the service. Five staff files (one clinical nurse leader, one RN, one recreational therapist, one housekeeper and one caregiver) 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.  There is an annual education plan that is outlined on the ‘clinical audit, training and compliance calendar’. The 2020 training plan has been completed and the 2021 training schedule was in progress. 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 are maintained. A competency programme is in place with different requirements according to work type (e.g. caregivers, RN, and household staff). Core competencies are completed, and a record of completion is maintained on staff files.  There are ten caregivers with level 4 Careerforce qualifications, five at level 3, twelve at level 2 and two have commenced their orientation. Level two is attained following completion of the orientation package. There are ten registered nurses (RN) with seven being interRAI trained. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The village manager, acting care centre manager and clinical nurse leader work 40 hours per week Monday to Friday and are available on call for any emergency issues or clinical support. There have been two care centre managers in the last 12 months with staff turnover being high overall. Caregivers interviewed confirmed that staff are replaced when off sick and a review of the roster identified confirmed this.  In the care centre, there are two RNs on the morning and afternoon shifts and one on night shift. They are supported by nine caregivers on morning shifts (seven full shift and two short shifts with staggered finishing times), eight caregivers on the afternoon shifts (six full shift and two short shifts with staggered finishing times). There is one RN and two caregivers on the night shift.  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.  Staff carry pagers that alert them to call bells and walkie talkies, so they can communicate effectively.  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 relatives confirmed that staffing levels are sufficient to meet the needs of residents. |
| Standard 1.3.12: Medicine Management  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. Safe storage was in evidence. There were no standing orders. There were no vaccines stored on site.  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 monitored daily and were within safe limits. Eye drops are dated once opened.  Staff sign for the administration of medications on the electronic system. Ten medication charts were reviewed. Medications are reviewed at least three-monthly by the GP. There was photo ID and allergy status recorded. ‘As required’ (PRN) medications had indications for use charted and effectiveness of the PRN medication was documented. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  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, led on site by a kitchen manager and lead chef. All kitchen staff have current food safety certificates. The kitchen manager 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 which are all computer based. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures were monitored, recorded, and were within safe limits. Food temperatures are checked, and these were also 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 four weekly menu cycle is approved by a dietitian and includes vegetarian options. The chef fortifies food for specific residents if requested by the dietitian. All residents/families interviewed were satisfied with the meals.  The food control plan expires 19 October 2022. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | 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. There is documented evidence of care plans being updated as residents’ needs changed.  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. The shortfall related to neurological observations in the previous audit has been addressed.  Care staff interviewed stated there are adequate clinical supplies and equipment provided including continence and wound care supplies.  Wound assessment, wound management and wound evaluation forms are in place for all wounds. Wound monitoring occurs as planned and includes wound nurse specialist input for chronic wounds and pressure injuries. High risk pressure injury residents have pressure injury prevention strategies documented in their care plans, including repositioning which was seen as being implemented as per the care plans.  Electronic monitoring forms are in use as applicable such as weight, vital signs, intentional rounding, and wounds. Behaviour charts are available for any residents that exhibit challenging behaviours. |
| Standard 1.3.7: Planned Activities  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 are two diversional therapists, one recreational therapist and one recreation assistant who plan and lead all activities over the seven day per week programme. The recreational therapist is currently completing the diversional therapy course. On the day of audit residents were seen to participate in baking, cognitive activities and receiving one-on-one time.  There is a monthly programme in large print on noticeboards in all areas plus a weekly activity schedule. Every month each resident is given a copy of the monthly programme and each week a schedule 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.  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.  There are regular church services and weekly communion.  There is a weekly van outing (twice weekly in summer) and the activities team 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 and regular pet therapy.  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.  Resident meetings are held bi-monthly. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Except for the short-term ACC 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  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building holds a building warrant of fitness which expires 1 August 2022. Preventative and reactive maintenance occurs. Request forms for repairs are available for residents and staff, these then being entered on to the ‘Tech1’ property management system and signed off electronically as repairs are completed. There is a full-time property manager who, with the property team, carries out the 52-week planned maintenance programme. The village manager and property manager are also on call after hours for urgent matters. The checking and calibration of medical equipment including hoists, has been completed annually and is next due 14 May 2022. All equipment has been tested and tagged. Hot water temperatures have been tested and recorded monthly with corrective actions for temperatures outside of the acceptable range. Preferred contractors are available 24/7.  The corridors are wide and promote safe mobility with the use of mobility aids and transferring equipment. Residents were observed moving freely around the areas with mobility aids, where required. There is outdoor furniture and seating with shade in place, and there is safe access to all communal areas. The external areas are landscaped and are wheelchair accessible.  The caregivers, and RNs interviewed stated that they have all the equipment required to provide the care documented in the care plans. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The infection control policy includes a surveillance policy, including a surveillance procedure, process for detection of infection, infections under surveillance, outbreaks and quality and risk management. Infection events are collected monthly and entered onto the 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 respiratory (RSV) outbreak in August 2021. Case logs and notification to Health Protection unit were sighted.  Hand sanitisers are appropriately placed throughout the facility. Visitors are asked not to visit if they are unwell. The majority of residents and all staff working in care have received both doses of the Pfizer Covid-19 vaccine. Residents and staff are offered the influenza vaccine. Covid-19 scanning/manual sign in is mandatory on entry to the facility and the use of face masks is required as part of level 2 restrictions. Covid-19 education has been provided for all staff, including hand hygiene and use of PPE. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There are policies around restraints and enablers. There were six residents requiring the use of a bedrail restraint and six residents using a bedrail enabler at the time of audit. The residents using the enablers 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.

|  |  |  |  |  |
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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.1.13.3  An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken. | PA Low | The service has a documented complaints process which includes clear timeframes for actions, however not all complaints were acknowledged within the specified timeframes as per the Code of Health and Disability Services Consumer Rights (The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers’ Rights (the Code). | Four of sixteen complaints were not acknowledged within five working days of receipt of the complaint. | Ensure all complaints are acknowledged in writing within the specified timeframes.  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.

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| No data to display |

End of the report.