

Summerset Care Limited - Summerset at Karaka

Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	Summerset Care Limited
Premises audited:	Summerset at Karaka
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 18 September 2017 End date: 18 September 2017
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:	52

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 Karaka currently provides rest home and hospital (geriatric and medical) level of care for up to 50 residents in the care centre and rest home level care for up to 40 serviced apartments. On the day of the audit, there were 52 residents, 47 residents in the care centre and five residents at rest home level of care in the serviced apartments.

The village manager is appropriately qualified and experienced and is supported by a care centre manager who oversees the care centre. The care centre manager is supported by a clinical nurse leader who has been in the role since October 2016.

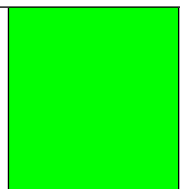
This unannounced surveillance audit was conducted against a subset of the Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of resident's and staff files, observations and interviews with residents,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

The service has addressed six of ten findings from the previous partial provisional and certification audit in relation to, staff roster/laundry duties, building/equipment compliance, safe/accessible areas, fire evacuation drill, fire evacuation plan and call bell system.

There continues to be improvements required around, care planning, medication management, food service and enabler risks.

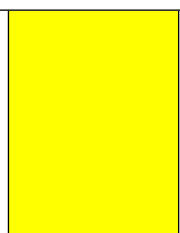
This surveillance audit identified further improvements required around the quality programme, and appraisals.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Residents and family are well informed including of changes in resident's health. The village manager and care centre manager have an open-door policy. Complaints and concerns have been managed and a complaints register is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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The quality and risk management programme includes service philosophy, goals and a quality planner. Quality activities are conducted, and this generates improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes. There is a health and safety management programme available to guide staff. Residents/family meetings have been held. Incidents and accidents are reported. There are human resources policies to support recruitment practices. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. An education and training programme for 2017 is in place. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Registered nurses are responsible for the provision of care and documentation at every stage of service delivery. The residents and family interviewed confirmed their input into care planning. A sampling of residents' clinical files validated the service delivery to the residents. Where progress is different from expected, the service responds by initiating changes to the care plan or recording the changes on a short-term care plan. There is an appropriate medicine management system in place.

Planned activities are appropriate to the group setting. The residents and family interviewed confirmed satisfaction with the activities programme. Individual activities are provided either within group settings or on a one-on-one basis. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met where required. There is a large well-equipped kitchen. Provision of the food service is provided by an external company. There are findings in the kitchen in relation to safe storage of food and food safety training.

Safe and appropriate environment

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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The building has a current warrant of fitness.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Restraint minimisation and safe practice policies are in place to guide staff in the use of an approved enabler and/or restraint. On the day of audit, there were no residents with restraint and two using enablers. Staff training has been provided around restraint minimisation and management of challenging behaviours.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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Summerset at Karaka has an infection control programme that complies with current best practice. The infection control programme is designed to link to the quality and risk management system. Records of all infections are kept and provided to head office for benchmarking.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	13	0	3	3	0	0
Criteria	0	40	0	3	3	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a complaints policy that describes the management of the complaints process. Information about complaints is provided on admission to residents and their families/whānau. Feedback forms are available for residents/whānau in various places around the facility. All staff interviewed were able to describe the process around reporting complaints. There is a complaint's register. There have been 13 complaints since the last certification audit in July 2016. All complaints reviewed had written investigations, timeframes and where required, corrective actions were documented and implemented. Results and outcomes of the investigations are fed back to complainants.</p> <p>Two of the complaints were made through the Health and Disability Commissioner (HDC) in July 2016 and January 2017. The HDC complaint from 2016 was investigated with corrective actions being followed-up. A letter from HDC confirmed that there would be no further action taken with the complaint. The HDC complaint from 2017 is still ongoing with an independent reviewer involved. Discussions with residents confirmed that any issues are addressed and they feel comfortable to bring up any concerns.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers</p>	FA	<p>Five residents (one hospital and four rest home) interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. The service has policies and procedures available for access to interpreter services for residents (and their family/whānau). Accident/incidents, complaints procedures and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any</p>

<p>communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>accident/incident. Ten incidents/accident forms reviewed include a section to record family notification. All forms evidenced family were informed or if family did not wish to be informed. One relative (hospital) interviewed confirmed that they are notified of any changes in their family member's health status. An interpreter policy and contact details of interpreters is available. Interpreter services are used where indicated.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Summerset at Karaka currently provides rest home and hospital (geriatric and medical) level care for up to 50 residents in the care centre (1st floor). There are 40 serviced apartments certified for rest home level care (across 3 floors) with the total bed numbers at Summerset at Karaka being 90 beds. On the day of the audit, there were 52 residents, 47 residents in the care centre (all beds are dual-purpose), including 19 residents at rest home level care and 28 residents at hospital level care (including one hospital resident on a palliative care contract). There were five residents at rest home level of care in serviced apartments on the ground floor of the care centre. There were no rest home residents in the newer block of apartments (which is connected by a covered walkway on the ground floor and an enclosed bridge walkway on the first floor).</p> <p>There is a current Summerset at Karaka operations business plan for 2017. The village manager and care centre manager receive support from the regional operations manager and clinical quality manager.</p> <p>The village manager (non-clinical) has been in the role since the village opened in October 2014. The village manager has a background in home and community management. The village manager is supported by a care centre manager (RN) who has been in the role since May 2017. The care centre manager is an experienced village manager in aged care. The care centre manager is supported by a clinical nurse leader who has been in the role since October 2016.</p> <p>The village manager has attended at least eight hours of leadership professional development relevant to their role.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects</p>	<p>PA Low</p>	<p>There is a documented Summerset organisation's quality and risk management system. The content of the policies and procedures is detailed to allow effective implementation by staff. The service's policies are reviewed at an organisational level. The quality and risk management system is designed to monitor contractual and standards compliance. The Summerset group has a 'clinical audit, training and compliance' calendar. The calendar schedules the training and audit requirements for the month and the village manager completes a 'best practice' sheet confirming completion of these requirements. The best practice sheet reports (but not limited to): meetings held, induction/orientation, audits, competencies and projects. This is forwarded to head office as part of the ongoing monitoring programme.</p> <p>The service is implementing the organisations internal audit programme. However, not all scheduled monitoring of internal audits had been completed. Issues arising from internal audits are developed into corrective action plans.</p>

<p>continuous quality improvement principles.</p>		<p>However, corrective action plans were not always completed and signed off for internal audits that were not compliant. There are monthly accident/incident benchmarking reports completed by the care centre manager that break down the data collected across the rest home, hospital and staff incidents/accidents. Infection control is also included as part of benchmarking across the organisation.</p> <p>Summerset's clinical quality manager analyses data collected via the monthly reports and corrective actions are required based on benchmarking outcomes. Summerset has a data tool "Sway- the Summerset Way". Sway is integrated and accommodates the data entered. There is a health and safety and risk management programme in place including policies to guide practice. The village manager is the health and safety officer (interviewed). Health and safety internal audits are completed. There is a meeting schedule including monthly quality improvement and staff meetings that includes discussion about clinical indicators (e.g., incident trends, infection rates and health and safety). Registered nurse/clinical meetings are held monthly.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Individual reports are completed for each incident/accident with immediate action noted and any follow-up action(s) required. Ten accident/incident forms were reviewed for July/August 2017. Each event involving a resident reflected a clinical assessment and follow-up by a registered nurse (RN). Data collected on incident and accident forms are linked to the quality management system. Discussions with the village manager and care centre manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Advised there have been no events since the last audit that would have triggered a section 31 notification. There have been no deaths referred to the coroner. The appointment of the care centre manager has been notified to HealthCERT.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in</p>	<p>PA Low</p>	<p>There are human resources policies to support recruitment practices. Five staff files reviewed, including one clinical nurse leader, two RNs and two caregivers evidenced employment contracts and completed orientation. However, annual performance appraisals were not completed for those staff files reviewed who had been employed for over twelve months. A register of registered nursing staff and other health practitioner practising certificates is maintained. Recruitment, qualifications, orientation training, performance management information is available on-site for staff. The orientation programme includes documented competencies and induction checklists.</p> <p>There is an annual education plan for 2017 that is outlined on the 'clinical audit, training and compliance calendar'.</p>

<p>accordance with good employment practice and meet the requirements of legislation.</p>		<p>In 2017, further training has been provided to caregivers around assessments and RNs around care planning and assessments. A competency programme is in place with different requirements according to work type, (e.g., caregiver, RN and kitchen). Core competencies are completed, and a record of completion is maintained on staff files, as well as being scanned into 'Sway' (sighted). The service has six of eight RNs trained in interRAI. However, performance appraisals are not all up to date.</p> <p>There are sufficient staff employed to cover the roster. The caregivers in the serviced apartments complete laundry duties so that caregivers in the care centre are available for resident needs. Caregivers interviewed reported that staffing was sufficient to complete cares and laundry. This previous partial provisional finding has been addressed.</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>	<p>FA</p>	<p>There is a safe staffing policy and safe staffing procedure, which describes staffing and is based on benchmarking information. There are clear guidelines for increase in staffing depending on acuity of residents. There is a full-time village manager and care centre manager who works from Monday to Friday. In the care centre (28 hospital residents and 19 rest home residents) there are two RNs (including the clinical nurse leader) on duty on the morning and afternoon shifts, and one RN at night. There are sufficient caregivers across all shifts to support the RNs. In the care centre, there are five caregivers on duty on the morning shift, four on the afternoon shift and two at night in the hospital area. There are two caregivers on the morning shift, one on the afternoon shift and one at night in the rest home area.</p> <p>In the serviced apartment area on the ground floor (there are five rest home residents) there are two caregivers on the morning shift, one on the afternoon shift and one at night. Caregivers are responsible for laundry and interviews identified that sufficient time is available to provide cares and complete laundry. There is a nurse's station on the ground floor and one on the first floor, which is placed in close proximity to the new wing in the care facility. The RNs from the care centre are responsible for the rest home residents in serviced apartments. A diversional therapist and recreational therapist provide a seven-day activity programme in the care centre. An activity person is based in the serviced apartments.</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</p>	<p>PA Moderate</p>	<p>Prescribed medications are delivered to the facility and checked on entry by the RN. There was one treatment room in the care centre housing all medications including medications for rest home residents in serviced apartments. There were separate drug trolleys for hospital, rest home and serviced apartment areas. The treatment room in the serviced apartment area was viewed and noted to be secure and appropriate for storage of medicines, however, was not in use at time of audit. At regular medication times medication is transported in a secure medication trolley dedicated to the serviced apartment area from the treatment room in the care centre and checked against the electronic medication chart. Aspects of the previous finding has been addressed, however the appropriate storage of medication within the treatment rooms continues to remain an area for improvement.</p> <p>There were no expired medications on the day of audit. The controlled drug register reviewed did not document</p>

<p>safe practice guidelines.</p>		<p>weekly checks and six-monthly physical stocktakes. The medication room fridge temperatures are monitored and recorded daily. There is an electronic medication management system in place. All staff administering medications had completed training for the electronic system. All RNs and senior caregivers authorised to administer medicines have current medication competencies. Medication rounds were observed and evidenced the medicine administered was signed off as the dose was administered. Administration records are maintained, as are staff specimen signatures. There was evidence of compliance around medication prescribing. There was one hospital resident who self-administers medication, three-monthly competencies were completed.</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>	<p>PA Low</p>	<p>There is a fully equipped purpose-built kitchen and all food is cooked on-site and managed by an external company. Food service provision is overseen by a qualified chef. A second assistant chef, a café assistant and four kitchen assistants provide cover across seven days per week. There is a food-services manual in place to guide staff. The chef advised that a resident nutritional profile is developed for each resident on admission; all nutritional profiles were available in the kitchen for all residents. The nutritional profile is reviewed at least six-monthly as part of the care plan review and the kitchen is notified of any changes as they are identified. The kitchen is able to meet the needs of residents who require special diets and the chef works closely with the RNs on duty. Kitchen staff were aware of specific resident needs (kept in a folder) including but not limited to food allergies, diabetic diets.</p> <p>Not all kitchen staff had completed food safety training. Cleaning schedules are evident and maintained. The chef (interviewed) was knowledgeable about resident individual needs and stated he sources daily feedback from residents regarding their individual likes and dislikes. The kitchen follows an eight-week rotating seasonal menu, which is reviewed annually by a dietitian (at organisational level). Refrigerators, freezers and cooked food temperatures are not always monitored and recorded. All food is stored appropriately. Food is delivered straight to the main dining room and a tray service is available and delivered via a hot box to resident rooms upon request. Review of the boiling water urn in the serviced apartment evidenced the urn has been managed safely. This previous finding has been addressed, however, fridge temperatures were not being routinely documented. Residents and relatives interviewed stated they were happy with the quality, presentation and variety of food served.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of</p>	<p>PA Moderate</p>	<p>Care plans are individually developed with the resident and family/whānau involvement is included where appropriate. The interRAI assessment process informs the development of the resident's care plan. Assessments and care plans include input from allied health including gerontology specialists, dietitians, District Health Board (DHB) nurse specialist, physiotherapy and podiatry. Care plans reviewed did not all include interventions to support current needs. Aspects of the previous finding has not been addressed.</p> <p>Short-term care plans are used for changes in health status, and these are now kept alongside the long-term care plans. This is an improvement on previous audit. Caregivers interviewed reported they accessed the resident file</p>

service delivery.		to review care plans and write progress notes and they found the care plans easy to follow. Family members interviewed confirm care delivery and support by staff is consistent with their expectations and they are involved in the care planning and review process.
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>When a resident's condition alters, the registered nurse initiates a review and if required a GP visit or nurse specialist consultant. There is documented evidence where care plans have been updated to reflect the changes in resident needs/supports (link 1.3.5.2). Short term care plans are developed for infections and acute changes.</p> <p>Monitoring forms in place include (but are not limited to); monthly weight, blood pressure and pulse, food and fluid charts and blood sugar levels. Progress notes document changes in health and significant events. Residents and relatives confirm their expectations are met and they are kept informed of any changes to health.</p> <p>There were ten wounds present on the day of audit. There was one unstageable pressure injury on the day of audit. There were seven skin tears, one skin lesion and one chronic wound with cellulitis. All wounds have been assessed and reviewed in appropriate timeframes. The RNs have access to specialist nursing wound care management advice through the DHB wound care nurse specialist if required. Adequate dressing supplies were sighted in the treatment rooms. The GP reviews wounds three monthly or earlier if there are signs of infection or non-healing. Chronic wounds and pressure injuries are linked to the long-term care plans.</p> <p>Continence products are available and resident files include a three-day urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the RNs interviewed.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The service employs an activities coordinator (ten hours per week) and an activities assistant (thirty hours per week) who deliver the activities programme across seven days per week. The programme provides activities that are meaningful and relevant for all residents. Time is spent with residents and families to further explore their individual life goals and to aid development of new and meaningful activities. Rest home and hospital residents join together for the activity programme. Participation of residents is monitored and documented. There are strong links with community. Village residents participate in some of the activities and celebrations on offer. Group activities reflect ordinary patterns of life and include at least weekly planned visits to the community. All residents in the facility may choose to attend any of the activities offered. Daily contact is made and one-on-one time is spent with residents who are unable to participate in group activities or choose not to be involved in the activity programme.</p> <p>Volunteers (two students) are involved in the activities programme. There are regular van outings for all residents (as appropriate), regular entertainment and involvement in community. Some residents go out to the local knitting group. The activity programme is developed a week in advance and a calendar is displayed throughout the facility. The activity plans reviewed were well documented and reflected the resident's preferred activities and interests.</p>

		Each resident has an individual activities assessment on admission and from this information, an individual activity care plan is developed. The activities plans were reviewed six-monthly where the activities coordinator joins the MDT meeting with nurses and families. Residents and families interviewed stated they enjoy the variety of activities offered and they have input into planning of the programme via daily feedback, resident surveys and at resident meetings.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Care plans reviewed had been evaluated by RNs six-monthly, or when changes to care occurred. Written evaluations describe the resident's progress against the resident's (as appropriate) identified goals. Care plans for short-term needs were evaluated and either resolved or added to the long-term care plan as an ongoing problem. The GP reviews residents at least three-monthly or when there is a change in health status. The family members interviewed confirmed they are invited to attend the GP visits and multidisciplinary care plan reviews.
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 has a current building warrant of fitness which expires on 8 October 2018. A code of compliance has been issued and expires October 2017. The nurses' station areas have been fully completed. The lift is fully operational and the walkways between buildings are open. Paths were completed for safe exits and areas were landscaped and fenced off. The previous findings have all been addressed.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	A fire drill was completed on 4 May 2017. The service has an approved fire evacuation plan. The call bell system has been signed off as fully operational. The previous findings have all been addressed.

<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>	<p>FA</p>	<p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control nurse uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the general practitioners and laboratory that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility. Effective monitoring is the responsibility of the infection control nurse. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. Surveillance data is available to all staff. Infections statistics are included for benchmarking. Corrective actions are established where infections are above the benchmark. All infections are documented monthly in an infection control register. There have been no outbreaks since previous audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The policies and procedures include definitions, processes and use of restraints and enablers. On the day of audit, there were no residents with restraint and two using enablers. Staff training has been provided around restraint minimisation and management of challenging behaviours.</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>	<p>PA Moderate</p>	<p>The organisational policy requires an assessment for residents who require restraint or enabler to be completed. Assessments were undertaken by suitably qualified and skilled staff, in partnership with the family/whānau. The risks associated with the use of a restraint or an enabler were not fully documented as part of the assessment process for two hospital residents using an enabler. This previous finding has not been addressed.</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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	<p>The organisation has a quality management system in place that schedules the internal audits and monitoring required. Not all scheduled monitoring of internal audits had been completed. Corrective action plans were not always completed and signed off for internal audits that were not compliant.</p>	<p>i) Ensure that the internal audit schedule calendar is adhered to.</p> <p>ii) Ensure that any corrective action plans required for any internal audits that are not compliant are completed and signed off.</p>	<p>i) Ensure that the internal audit schedule calendar is adhered to.</p> <p>ii) Ensure that any corrective action plans required for any internal audits that are not</p>

				compliant are completed and signed off. 90 days
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	<p>There is an annual education plan for 2017 that is outlined on the 'clinical audit, training and compliance calendar'. In 2017, further training has been provided to caregivers around assessments and RNs around care planning and assessments. A competency programme is in place with different requirements according to work type, (e.g., caregiver, RN and kitchen). Core competencies are completed and a record of completion is maintained on staff files, as well as being scanned into 'Sway' (sighted). The service has six of eight RNs trained in interRAI. However, annual performance appraisals were not completed for those staff files reviewed who had been employed for over twelve months</p>	<p>Three of five staff files did not evidence an up-to-date annual performance appraisal</p>	<p>Ensure that annual performance appraisals are completed for all staff</p> <p>90 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing,</p>	PA Moderate	<p>Electronic medicine charts evidenced residents' photo identification, recorded allergies and three-monthly medicine reviews. The residents' medicine charts</p>	<p>(i) Stock medication is currently sitting in a box and has not been safely stored in the cupboard. (ii) Robotic packs of PRN medication in the medication drawer of the</p>	<p>(i- ii) Ensure a process is implemented where all medications</p>

<p>administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>		<p>recorded all medications a resident was taking (including name, dose, frequency and route to be given). Sixteen medication charts were reviewed (ten hospital and six rest home). There is one CD cupboard where medicines were stored appropriately and safely. There is a controlled drug register maintained by RNs. The controlled drug register reviewed was not always maintained as per medication legislation and guidelines.</p> <p>There were separate drug trolleys for hospital, rest home and serviced apartment areas. The treatment room in the serviced apartment area was viewed and noted to be secure and appropriate for storage of medicines, however, was not in use at time of audit. At regular medication times medication is transported in a secure medication trolley dedicated to the serviced apartment area from the treatment room in the care centre and checked against the electronic medication chart. Aspects of the previous finding has been addressed; however, the appropriate storage of medication continues to remain an area for improvement.</p>	<p>trolley are all mixed together and not systematically stored. (iii) There were documentation shortfalls identified in the controlled drug register including; a) Weekly controlled drug checks were not always completed; (b) There were examples of incorrect record keeping entries for medications discarded; the entry on 15 June 2017 documented 'medication discarded' however, did not clearly state where this medication was discarded to; there were four entries in May 2017 documenting 'borrowed for another resident'</p>	<p>are stored appropriately and safely. (iii) Ensure the controlled drug register is maintained and evidences accurate record keeping as per medication legislation and guidelines</p> <p>30 days</p>
<p>Criterion 1.3.13.5 All aspects of food procurement, production, preparation, storage, transportation, delivery,</p>	<p>PA Low</p>	<p>There is a fully functional kitchen and all food is cooked on-site. There is a food-services manual in place to guide staff. Review of the</p>	<p>(i) Not all kitchen staff have completed food safety training (four kitchen assistants/café assistant).</p>	<p>(i) Ensure all kitchen staff have completed</p>

and disposal comply with current legislation, and guidelines.		boiling water urn in the serviced apartment evidenced the urn has been managed safely. This previous shortfall has been addressed, however gaps were identified around food safety training and monitoring of fridge temperatures in the kitchen.	(ii) Fridge temperatures were not always documented.	food safety training. (ii) Ensure fridge temperatures are documented as required. 90 days
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	PA Moderate	Short-term care plans are used for changes in health status, and these are now kept alongside the long-term care plans. The RNs interviewed confirmed that interventions are documented in the care plan for all assessed care needs. However, in the files sampled, interventions for all assessed care needs had not been documented to reflect current support needs. The previous finding has not fully been addressed.	Two of five care plans did not reflect the resident's current level of support for; (i) one hospital resident with pain management instructed by specialist, (ii) one hospital resident with a pressure injury had no instruction re skin integrity checks or skin care, management of current UTI, and management of weight-loss (link tracer)	Ensure all interventions are documented to support resident current needs. 90 days
<p>Criterion 2.2.2.1</p> <p>In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:</p> <p>(a) Any risks related to the use of restraint;</p> <p>(b) Any underlying causes for the relevant behaviour or condition if known;</p> <p>(c) Existing advance directives the consumer may have made;</p>	PA Moderate	The restraint coordinator reviews the assessments completed by the RNs and discusses the outcome of the assessment with the resident and/or family/whānau. Not all sections of the restraint/enabler assessment form had been completed in the two files sampled. The risks associated with the use of a restraint or an enabler were not fully documented as part of the assessment process	The risks associated with the use of a restraint or an enabler were not fully documented as part of the assessment process for two hospital residents using an enabler.	Ensure that all sections of the restraint assessment form are completed, and the risks associated with the use of the

<p>(d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;</p> <p>(e) Any history of trauma or abuse, which may have involved the consumer being held against their will;</p> <p>(f) Maintaining culturally safe practice;</p> <p>(g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);</p> <p>(h) Possible alternative intervention/strategies.</p>		<p>for two hospital residents using an enabler.</p>		<p>restraint or enabler are documented as part of the assessment process.</p> <p>60 days</p>
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.