Summerset Care Limited - Summerset Mountain View

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 Mountain View
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 14 December 2017 End date: 14 December 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: 48

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
	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 Mountain View is part of the Summerset group of aged care facilities. The service provides rest home and hospital (medical and geriatric) level care for up to 52 residents in the care centre and up to 20 residents at rest home level of care in serviced apartments. On the day of the audit there were 48 residents. The service is managed by a non-clinical village manager and an experienced clinical manager/registered nurse. The residents and relatives interviewed spoke positively about the care and support provided.

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.

Five of eight previous findings from the previous certification and partial provisional audit have been addressed in relation to quality improvement meetings and quality data, internal audits and corrective actions, hazard register, training programme and restraint assessments.

There continues to be improvements around complaints documentation, care plans and wounds.

There was one further improvement identified at this surveillance audit around medication chart reviews.

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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

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. Complaint forms and advocacy brochures are available. Information about the Code and related services is readily available to residents and families. An advocate from Age Concern attends resident's meetings.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.

Summerset Mountain View is implementing a quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to a number of meetings including monthly quality and management meetings. Annual 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, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care. There is a staffing policy in place.

Continuum of service delivery

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

The registered nurses are responsible for all stages of provision of care. Assessments, interRAI assessments, development of care plans and evaluations were completed within the required timeframes. Risk assessment tools and monitoring forms were available and implemented. Resident centred care plans were individualised and included the input of allied health professionals in resident care.

Two recreational therapists implement an integrated activity programme for the rest home and hospital residents. The activities meet the individual recreational needs and preferences of the resident groups. There are outings into the community and visiting entertainers.

There are medicine management policies in place that meets legislative requirements. Staff responsible for the administration of medications complete annual medication competencies and education.

The food service is contracted to an external company. Resident's individual dietary needs were identified and accommodated. Staff have attended food safety and hygiene training.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.

The building has a current schedule of compliance issued September 2017.

Restraint minimisation and safe practice

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

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. The restraint coordinator maintains a current register. Staff receive regular education and training on restraint minimisation. There were two rest home residents with enablers and two hospital residents with restraint on the day of audit.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.

The infection control surveillance programme is appropriate to the size and complexity of the service. Results of surveillance are acted upon, evaluated and reported to relevant personnel. The infection control officer uses the information obtained through 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)
Standards	0	14	0	1	3	0	0
Criteria	0	39	0	1	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
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	PA Moderate	The organisational complaints policy stated that the village manager has overall responsible for ensuring all complaints (verbal or written) are fully documented and investigated. There is an electronic complaint's register that includes relevant information regarding the complaint. Not all documentation for follow-up letters and resolution were available. The number of complaints received each month is reported monthly to staff via the various meetings. There were 12 complaints received in 2017 (year to date). Four of the complaints remain open (including two DHB complaints) and are being actioned by head office. Further complaints had been closed out, but did not always evidence follow-up letters and outcomes being completed within the required timeframes. 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. The previous finding around complaint documentation remains.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and	FA	Residents (three rest home and two hospital) and family members (two rest home) stated they were welcomed on entry and were given time and explanation about services and procedures. Two rest home relatives interviewed also stated they are informed of changes in the health status of residents and incidents/accidents. Resident/relative meetings are held monthly with an advocate from Age Concern invited to attend. The village manager and the care centre manager have an open-door policy. The service produces a newsletter for residents and relatives. Residents and family are advised in writing of their eligibility and the process to become a

provide an environment conducive to effective communication.		subsidised resident should they wish to do so. The service has policies and procedures available for access to interpreter services for residents (and their family/whānau). If residents or family/whānau have difficulty with written or spoken English, the interpreter services are made available.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	The service provides care for up to 52 residents at hospital (geriatric and medical) and rest home level care. At the time of the audit there were 30 rest home level residents in the care centre including one on respite care and five residents receiving rest home level care in the serviced apartments. There were 13 residents receiving hospital level care including one resident funded by ACC. All residents except the one under ACC were under the aged related care contract. All beds in the care centre are dual-purpose. The Summerset Group Limited Board of Directors have overall financial and governance responsibility and there is a company strategic business plan in place. Summerset Mountain View has a site-specific business plan and goals that is developed in consultation with the village manager, care centre manager and regional operations manager (ROM). The quality plan is reviewed regularly throughout the year. There is a full evaluation at the end of the year. The 2016 evaluation was sighted. The village manager has been in the current role at Summerset since 2013. The village manager is supported by a care centre manager. The care centre manager has been in the position for 18 months. The care centre manager is a registered nurse who has experience in district nursing and palliative care. The care centre manager is supported by the clinical nurse lead. Village managers and care centre managers attend annual organisational forums and regional forums over two days. There is a regional operations manager who is available to support the facility and staff. The village manager has attended at least eight hours of leadership professional development relevant to the role.
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 Mountain View 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. The content of policy and procedures are detailed to allow effective implementation by staff. The Summerset group has a 'clinical audit, training and compliance' calendar. The calendar schedules the training and audit requirements for the month and the care centre manager reports completion of requirements. All training has occurred as planned for 2017. Summerset Mountain View reporting to head office includes (but is not limited to): complaints, staff turnover, meetings held, audits, quality indicators for infections, incidents and accidents, health and safety and projects is forwarded to head office as part of the ongoing monitoring programme. There is a meeting schedule including a combined monthly quality management meeting that includes discussion about clinical indicators (e.g. incident trends, infection rates), health and safety, restraint and complaints. A new

		agenda template ensures all quality and benchmarking data is discussed at quality and staff meetings. Registered nurse meetings are held monthly. Caregivers meetings are held fortnightly. Health and safety meetings occur monthly. There are other facility meetings held such as kitchen and activities. The previous finding around meetings and analyse of quality data has been addressed An annual residents/relatives survey completed (September 2017) reports overall 96% feedback of experience being good or very good. The service is implementing an internal audit programme that includes aspects of clinical care. Issues arising from internal audits an analyse of quality data are developed into corrective action plans, reviewed by the CCM and signed by the VM. The previous finding around internal audits and corrective actions has been addressed. Monthly and annual analysis of results is completed and provided across the organisation. There are monthly accident/incident benchmarking reports completed by the care centre manager that break down the quality data collected across the rest home and hospital and staff incidents/accidents. Summerset has a data tool "Sway- the Summerset Way" which is integrated and accommodates the data entered. Health and safety internal audits are completed. There is a health and safety and risk management programme in place including policies to guide practice. The property manager is the health and safety representative (interviewed). The hazard register includes identified risks and these are reviewed at regular meetings. The previous finding around the hazard register has been addressed. Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls.
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 has been collected and analysed. Discussions with the service confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. A notification to public health/DHB for an outbreak in July 2017 was sighted. Fourteen resident related incident reports for October and November 2017 were reviewed (seven falls, three skin tears, one medication error and three other category). All reports and corresponding resident files reviewed evidence that appropriate clinical care has been provided following an incident. The incident reporting policy includes definitions and outlines responsibilities including immediate action, reporting, monitoring including neurological observations (link 1.3.6.1) and corrective action to minimise and debriefing. Data is linked to the organisation's benchmarking programme and used for comparative purposes.

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 list of practising certificates is maintained. Five staff files (one care centre manager, one RN, one recreational therapist and two caregivers) were reviewed and all had relevant documentation relating to employment. Performance appraisals had been completed annually for those staff who have been employed for over 12 months. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme includes documented competencies and induction checklists (sighted in files of newly appointed staff). Staff interviewed were able to describe the orientation process and believed new staff were adequately orientated to the service. There is an annual education plan that is outlined on the 'clinical audit, training and compliance calendar'. The plan is being implemented. A competency programme is in place with different requirements according to work type (e.g. caregivers, registered nurse (RN) and kitchen assistant). Core competencies are completed, and a record of completion is maintained on staff files and well as being scanned into 'Sway'. Five caregivers interviewed were aware of the requirement to complete competency training. Caregivers complete an aged care programme. There are 24 permanent caregivers employed, all 24 have either completed aged care qualifications or are currently working on level three qualifications. The previous finding around staff training has been addressed.
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 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 lead works full time Thursday to Sunday. In the care centre, there is an RN on duty 24/7. There are three caregivers on morning shifts, three on the afternoon shifts and three on night shifts. An enrolled nurse is rostered to four afternoon shifts per week. The RN on duty provides oversight to the rest home residents in the serviced apartments. One caregiver is on duty in the serviced apartments on a morning shift, an afternoon shift and a night shift to assist the five rest home residents. Staffing levels and skills mix policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery. A staff availability list ensures that staff sickness and vacant shifts are covered. Caregivers interviewed confirmed that staff are replaced when off sick. Interviews with residents (three rest home and two hospital) and relatives confirmed that staffing levels are sufficient to meet the needs of residents.
Standard 1.3.12: Medicine Management Consumers receive	PA Low	There are medicine management policies and procedures that align with recognised standards and guidelines for safe medicine management practice in accordance with the Medicines Care Guide for Residential Aged Care 2011. The RNs are responsible for the administration of medications and have completed medication competencies,

medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.		annual medication education and syringe driver training. All medications and robotic rolls were evidenced to be checked on delivery with any discrepancies fed back to the supplying pharmacy. There was one self-medicating rest home resident with a self-medication competency and monitoring in place. All medications were stored correctly. The medication fridge temperature is monitored weekly. Ten resident medication charts (four hospital and six rest home) were reviewed on the electronic medication system were reviewed. Staff recorded the time, date and effectiveness of as required medications. All 'as required' medications had an indication for use. Not all medication charts on the electronic medication system had been reviewed three monthly by independent GPs.
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	Medirest is contracted for the provision of meals on-site and to the village café. The care centre kitchenette and main dining is located on the second level with a downstairs dining room for serviced apartment residents. There is an eight-week rotating seasonal menu approved by the organisational dietitian. Resident likes/dislikes and preferences are known and accommodated with alternative meal options including a vegetarian option. Texture modified meals, fortified foods, protein drinks and diabetic desserts are provided. The cook receives a dietary profile for each resident. The chef (interviewed) is notified of any changes to resident's dietary requirements resident preferences. Specialized crockery and utensils are provided as required. Meals are delivered in hot boxes to the dining areas. The fridge and freezer temperatures are monitored and recorded. End cooked food temperatures are recorded on all meats and menu foods. All foods are stored correctly and date labelled. Cleaning schedules are maintained. Chemicals are stored safely within the kitchen. Staff were observed wearing correct personal protective clothing. Staff working in the kitchen have food handling certificates and chemical safety training. Feedback on the meals are provided through direct feedback, resident meetings and surveys.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Moderate	Resident-centred care plans describe the individual support and interventions required to meet the resident goals. The care plans reflect the outcomes of risk assessment tools. However, interventions for one hospital resident had not been updated to reflected the required supports/needs. The previous finding remains. Short-term care plans were in use for changes in health status. These are evaluated regularly and either resolved or if an ongoing problem added to the long-term care plan. There is documented evidence of resident/family/ involvement in the care planning process. Residents/relatives interviewed confirmed they participate in the care planning process.
Standard 1.3.6:	PA	When a resident's condition changes, the RN initiates a review and if required a GP or nurse specialist

Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	Moderate	consultation. Relatives interviewed state their relative's needs are met and they are kept informed of any health changes. There was documented evidence in the resident files of family notification of any changes to health including infections, accidents/incidents, and medication changes. Residents interviewed state their needs are being met. Adequate dressing supplies were sighted. Initial wound assessments with ongoing wound evaluations and treatment plans were in place for residents with wounds. Wounds are re-assessed at least monthly. Evaluation comments and photos monitor the healing progress. The CNL confirmed there was a wound nurse specialist available as required. Not all wound dressing had been changed as per the documented frequency. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed. Monitoring forms are available to monitor resident health and progress against implemented interventions. There was a shortfall around neurological observations. The previous finding around implementation and wound documentation remains.
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	The service employs a recreational therapist who is a qualified diversional therapist (DT) for 25 hours over four days and a DT in training for three days with one day where both are on duty. The activity team attend Summerset training sessions and the regional DT group. Both activity persons have current first aid certificates. The integrated rest home/hospital programme is planned a month in advance and includes set activities with the flexibility to add other activities of interest or suggestions made by residents. Activities meet the recreational needs of the residents ensuring all residents have the opportunity to attend activities such as exercises, newspaper reading, arts and crafts, board games and quizzes. One-on-one time is spent with residents who choose to stay in rooms or unable to participate in group activities. The service has a wheelchair access van for regular weekly outings for outings, shopping, and attending community groups/functions including concerts and events such as the festival of the lights. Community visitors include entertainers, school children, kapa haka groups, pastoral visitors, RSA visitors, pet therapy and guide dog visits. There are many meaningful activities that are integrated with rest home and village residents. Rest home residents are invited and assisted to attend the care centre activity programme. Residents are encouraged to maintain their former community links. Church services are held. Resident meetings provide an opportunity for residents to feedback on the programme. The recreational therapists are involved in the multidisciplinary review which includes the review of the activity plan.
Standard 1.3.8:	FA	There is evidence of resident and family involvement in the review of resident centred care plans. Initial care plans

Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.		were evaluated by the registered nurses within three weeks of admission. Written evaluations were completed six monthly or earlier for resident health changes. There is evidence of multidisciplinary (MDT) team involvement in the reviews including input from the GP and any allied health professionals involved in the resident's care. Families are invited to attend the MDT review and asked for input if they are unable to attend. Short-term care plans sighted have been evaluated by the RN. The GP completes three monthly 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	A certificate of compliance for the entire building was issued in September 2017.
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 SWAY electronic system. The infection control officer provides infection control data, trends and relevant information to the infection control committee and clinical/quality meetings. Areas for improvement are identified and corrective actions are developed and followed up. The facility is benchmarked against other Summerset facilities of similar size and benchmarking results are fed back to the infection control officer and used to identify areas for improvement. Infection control audits are completed, and corrective actions are signed off (sighted). Surveillance results are used to identify infection control activities and education needs within the facility. A confirmed norovirus outbreak in July 2017 was appropriately managed and reported.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	There are policies around restraints and enablers. Restraint use is minimised and used as a last resort for resident safety. The service currently has two hospital level of care residents assessed as requiring the use of restraint (bed rails). There are two rest home residents with enablers (bedrails). Voluntary consent had been obtained for enablers. Ongoing consultation with the resident and family/whānau is also identified. Staff receive training around restraint minimisation that includes annual competency assessments.

Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	Only registered nursing staff can assess the need for restraint. Restraint assessments are based on information in the resident's care plan, discussions with the resident and family and observations by staff. Two of two hospital level residents' files where restraint (bedrails) was being used were reviewed. Each file included a restraint assessment and consent form that was signed by the resident's family. A restraint assessment tool identified risks related to the use of restraint. Interventions to prevent injury and maintain cares during periods of restraint use were documented in the resident centred care plans. The previous finding around assessments has been addressed.

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)
Criterion 1.1.13.3 An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.	PA Moderate	All complaints received are entered on the Summerset SWAY on line data base. Documentation and evidence is maintained in an onsite folder. All complaints are investigated.	The on-line sway complaints register evidenced five resolved complaints for 2017. The on-site complaints register evidenced eight resolved complaints and four currently with Summerset head office for actioning. The outcomes of two of eight complaints did not occur within required timeframes.	Ensure the SWAY complaints register accurately reflects all received complaints and that the onsite documentation correlates with the on-line system. Ensure all follow-up complaint outcomes occur within ten working days 60 days
Criterion 1.3.12.1 A medicines management system is implemented to	PA Low	The service uses an electronic medication system. The medication charts had photograph identification and allergy status recorded. Each medication was dated with	Four of 10 medication charts on the electronic medication system were overdue for GP review. The risk is considered to be low	Ensure all medication charts are reviewed by the GP at least three

manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.		reason for commencing the medication. Medication signing sheets corresponded with the medication charts. Six of 10 medication charts had been reviewed by the GP at least three monthly.	as the residents have been seen and examined at least three monthly.	monthly. 30 days
Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	PA Moderate	Four of five resident long-term care plans (one hospital and three rest home) reflected the current needs/supports to meet the resident goals.	One hospital resident long-term care plan had not been updated to reflect the resident's current needs including pain management, weight management and management of oedematous legs.	Ensure all long-term care plans reflect the resident's current needs/supports. 60 days
Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Moderate	There are a number of monitoring forms and charts available for use including (but not limited to) pain monitoring, blood sugar levels, weight, wound evaluations, food and fluid intake. Neurological observations following unwitnessed falls had not been commenced and those in place had not been completed. Not all wounds had dressing changes at the required frequency.	(i)Three unwitnessed falls did not have neurological observations completed. Two neurological observations commenced had not been completed as per protocol and (ii) Five of the seven wounds did not have dressing changes as per the documented frequency.	(i)Ensure neurological observations are completed following unwitnessed falls, and (ii) Ensure dressing changes occur at the required frequency. 60 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

End of the report.