

# Summerset Care Limited - Summerset In The Sun

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## 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:

<b>Legal entity:</b>	Summerset Care Limited
<b>Premises audited:</b>	Summerset in the Sun
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 27 November 2019    End date: 28 November 2019
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	65

# Executive summary of the audit

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## 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 in the Sun provides rest home and hospital (geriatric and medical) level care for up to 59 residents in the care centre and rest home level care for up to 41 residents in the serviced apartments. On the day of the audit there were 56 residents in the care centre and 9 rest home residents in serviced apartments.

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

The service is managed by an experienced village manager (VM) who also a registered nurse with a current practicing certificate. She is supported by a care centre manager previously the clinical leader and has been in the current role for seven months. The management team is supported by a stable registered nurse and caregiving team. The residents and relatives interviewed spoke positively about the care and support provided.

There were no areas identified for improvement at this surveillance audit.

## 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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There is documented evidence of family being notified for any changes to their relative's health. A review of accidents/incidents evidenced relative notification. Residents and relatives are kept informed on activities and facility matters through meetings and newsletters. Complaints processes are being implemented and complaints and concerns are managed and documented.

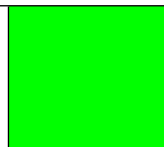
## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Summerset in the Sun implements 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 improvement meetings. Annual surveys and resident meetings provide residents and families with an opportunity for feedback about the service. Quality performance is reported to staff at facility meetings and includes discussion about incidents, infections, health and safety 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 with sufficient numbers of staff on duty to provide safe delivery of care.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.



Standards applicable to this service fully attained.

Assessments, care plans and evaluations are completed by the registered nurses. Risk assessment tools and monitoring forms are available. Short-term care plans are in use for changes in health status. The general practitioner interviewed spoke highly of the clinical staff and care delivered.

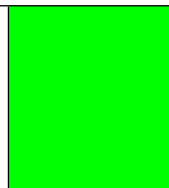
There are two diversional therapists employed to implement the seven days per week activities programme. The activities provided are meaningful and reflect ordinary patterns of life and residents and relatives expressed satisfaction with the programme. There are outings into the community, volunteer involvement and visiting entertainers.

There are medication management policies that are comprehensive and direct staff in terms of their responsibilities in each stage of medication management. Medication profiles are electronic and meet legislative guidelines. Staff who administer medications have been assessed as competent to do so.

Food services policies and procedures are appropriate to the service setting. The food service is provided by an external contractor. Resident's individual dietary needs are identified, documented and reviewed on a regular basis. Visual inspection of the kitchen shows evidence of compliance with current legislation and guidelines. Residents and family members interviewed were complimentary of the food service provided and reported that individual preferences are well catered.

## 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.

There is a current building warrant of fitness. Planned and reactive maintenance systems are in place. All equipment has been serviced and calibrated as required.

## 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. Staff receive regular education and training on restraint minimisation. There were no residents with enablers or 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 officer (registered nurse) uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. These included audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Somerset 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)
<b>Standards</b>	0	16	0	0	0	0	0
<b>Criteria</b>	0	41	0	0	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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 organisational complaints policy states that the village manager has overall responsibility 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. There has been one relative complaint regarding resident care for 2019 to date. Documentation included acknowledgement of the complaint and outcome of the investigation. The letter also offered independent advocacy if the complainant was not satisfied with the outcome. Complaints and compliments are discussed at facility meetings.</p> <p>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.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an</p>	FA	<p>Five residents (three hospital and two rest home including one resident in the serviced apartments) and family members (three hospital) interviewed, stated they are informed of changes in the health status of residents and incidents/accidents. Fifteen accident/incidents from October 2019 reviewed identified the relatives had been informed.</p> <p>Resident/relative meetings are held monthly and the service produces a newsletter that keeps residents and relatives informed of facility matters, events and survey results. The village manager and the care centre manager have an open-door policy. Residents and family are advised in writing of their eligibility and the process to become</p>

<p>environment conducive to effective communication.</p>		<p>a subsidised resident should they wish to do so.</p> <p>The service has policies and procedures available for access to interpreter services for residents (and their family/whānau).</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>The service provides care for up to 100 residents at hospital (geriatric and medical) and rest home level of care. There are 59 dual-purpose beds in the care centre on level one and 41 serviced apartments certified for rest home level of care. On the day of the audit, there were 65 residents in total - 33 residents at rest home level including five respite residents and nine rest home residents in the serviced apartments and 32 hospital level residents. One hospital resident previously in the serviced apartments with a MOH dispensation for hospital level of care has transferred to the care centre.</p> <p>The Summerset Group Limited Board of Directors have overall financial and governance responsibility and there is an overarching company strategic business plan in place with goals around dementia friendly facilities, recycling and no use of plastics, computer base systems and health and safety. Summerset in the Sun has a site-specific business plan and goals that are developed in consultation with the village manager, care centre manager and regional manager. The service has developed a village focus group to achieve the dementia friendly goals and a falls reduction plan has been implemented in April 2019. The business plan and goals are reviewed quarterly. There are weekly management meetings and the village manager reports to the regional manager. The regional manager is readily accessible and visits the site monthly.</p> <p>The village manager has been in the role at Summerset for three years and six months. The village manager is a RN with a current practicing certificate and holds a master's degree in nursing. She attended the annual two-day Summerset conference in March 2019 and attended an information session for emergency preparedness held at civil defence November 2019. The care centre manager attended a gerontology conference. The village manager and care centre manager attend the three monthly DHB forums.</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</p>	<p>FA</p>	<p>Summerset in the Sun is implementing an organisational quality and risk management system. There are policies and procedures being implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed on a regular basis from head office. The content of policy and procedures are detailed to allow effective implementation by staff. Staff are informed on new/reviewed policies through facility meetings.</p> <p>The Summerset group has a 'clinical audit, training and compliance' calendar. The calendar schedules the training and audit requirements for the month. The village manager and care centre manager complete monthly reports confirming completion of requirements. There is a meeting schedule including monthly quality improvement meetings, registered nurse meetings and all staff/caregiver meetings. Quality data such as infections,</p>

<p>system that reflects continuous quality improvement principles.</p>		<p>accidents/incident, hazards, restraint, audit outcomes, concerns/complaints, review of quality goals and survey results are discussed and documented in meeting minutes. Meeting minutes and quality data reports and graphs are available to all staff.</p> <p>An annual residents/relatives survey has been completed by an external company for 2019. Results reported 96.1% overall satisfaction rate. The results have been communicated to residents and staff.</p> <p>The service is implementing an internal audit programme that includes environmental, infection control, health and safety, consumer rights and aspects of clinical care. The company goal is for 80% compliance for all audits. Corrective action plans were developed and followed-up for all audit results less than expected. Monthly and annual analysis of results is completed and communicated to all staff through meetings. The village manager signs off all completed corrective action plans (as sighted).</p> <p>There are monthly accident/incident benchmarking reports completed by the care centre manager that break down the data collected across the rest home and hospital. Infection control is also included as part of benchmarking across the organisation. Data is analysed and corrective actions are required based on benchmarking outcomes. The village manager and regional manager is alerted automatically of any high-level accident/incidents (resident, staff and environmental).</p> <p>There is a health and safety and risk management programme in place including policies to guide practice that is generated from the national health and safety manager at head office. The service has a health and safety officer (village manager) and health and safety representatives who form the health and safety committee which meet to review the health and safety plan, hazards, accidents and incidents and the hazard register. The committee are representative of management and staff from all areas. Two health and safety representatives were interviewed who had completed their health and safety training as well as two other representatives on the committee. The representative's complete weekly village walk-arounds, internal audits and health and safety induction for new staff and contractors. Each month there is a focus on one of the golden rules of safety which is displayed on the staffroom health and safety noticeboards along with meeting minutes and other health and safety information. The hazard register has been reviewed November 2019. The national health and safety manager have recently completed a site environmental audit with 97% result.</p> <p>Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. A village-wide fall reduction programme has been commenced (April 2019) with resident and relative education around falls prevention, muscle strength and balance, exercise programmes with physiotherapist involvement, appointment of an RN with a fall's prevention portfolio and purchase of a massage chair in the care centre. The project is being reviewed and monitored regularly and is not yet ready for a formal evaluation.</p>
<p>Standard 1.2.4:</p>	<p>FA</p>	<p>Incident and accident data is entered into the electronic VCare system. Fifteen incidents/accidents for the month of</p>

<p>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>October were reviewed. All incidents/accidents identified timely RN assessments and notification of relatives. All falls have a documented post-fall assessment. All reports and corresponding resident files reviewed evidenced that appropriate clinical care had been provided following an incident. Neurological observations had been completed where required. Data had been collated and analysed for trends with monthly comparisons made. Data is linked to the organisation's benchmarking programme and used for comparative purposes.</p> <p>Discussions with the service confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been three section 31 notifications including one suspected deep tissue (November 2019), one death on-route to hospital – police involved (August 2019) and one notification of change of clinical manager (April 2019).</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are resources policies to support recruitment practices. A record of RN and allied health professionals practising certificates is maintained. Six staff files (one care centre manager, one clinical nurse leader, one RN, one diversional 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 staff files reviewed). Staff interviewed were able to describe the orientation process and believed new staff were orientated well to the service. The service employs an RN educator for 10 hours per week. There is an annual education plan that is outlined on the 'clinical audit, training and compliance calendar'. The plan is being implemented. Staff who do not attend in-services are required to read the education content. Staff complete competencies relevant to their role such as medication, hand hygiene, moving and handling, wound and restraint competencies. There is access to DHB study days and on-line palliative care training. There are 12 RNs (including one RN on leave) with 11 RNs and the care centre manager interRAI trained. The service is linked to the professional development recognition programme (PDRP) at the DHB and four RNs have completed their PDRP.</p> <p>There is one RN assessor in training. Caregivers complete level two of the aged care programme during orientation and have the opportunity to further their qualifications.</p>
<p>Standard 1.2.8: Service Provider Availability</p>	FA	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. There are clear guidelines for increase in staffing depending on acuity of residents. 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.</p>

<p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>The clinical nurse leader works full time Tuesday to Saturday.</p> <p>In the care centre, there is are two RNs on morning duty, afternoon shifts and night shift. One RN on night shift is designated to work with the caregiver on night shift.</p> <p>There are seven caregivers on full morning shifts. They are supported by an additional caregiver two mornings a week for specific tasks such as nail cares. A “float” caregiver is available from the serviced apartments.</p> <p>On the afternoon shifts there are six caregivers on the full shift and one until 9 pm. There is also a “float” caregiver from the apartments available until 9 pm.</p> <p>There is one caregiver on night shift with the two RNs.</p> <p>In the serviced apartments there are three caregivers on morning shift (one full shift and two finishing at 1 pm – one caregiver is the “float” for the care centre). There are two caregivers on the afternoon shift (one full shift and one finishing at 9 pm - also the “float” for the care centre). There is one caregiver on night shift.</p> <p>Interviews with staff, residents, and relatives confirmed that staffing levels are sufficient to meet the needs of residents.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The service medication policies and procedures follow recognised standards and guidelines for safe medicine management practice in accordance with the Medicines Care Guide for Residential Aged Care 2011. There is one locked medication room for the upstairs hospital/rest home and rest home residents in the serviced apartments. The facility uses two weekly supplied robotic sachets for regular and ‘as required’ medication delivered by the supplying pharmacy. Medications are checked against the electronic system on arrival at the facility by the night RNs. Any discrepancies are fed back to the pharmacy.</p> <p>An electronic medication documentation system is used, and 12 medication records demonstrated that best practice for medication prescribing and documentation is implemented including indications for use documented for all ‘as required’ medications.</p> <p>All medications are kept in locked trolleys in the treatment room. The medication fridge temperature is recorded daily. There were no residents self-administering/self-medicating. There are no standing orders.</p> <p>All RNs that check and administer medication are competent (rechecked annually) and have received medication management training (there is always a minimum of two RNs on duty).</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid</p>	<p>FA</p>	<p>There is a large kitchen and an external provider is contracted for the provision of meals on site. There is a comprehensive MPI kitchen manual in place. There is an eight-week seasonal menu approved by the dietitian. The chef receives a dietary profile for each resident with dietary requirements, special diets, food allergies, likes and</p>

<p>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>dislikes. Alternatives are offered. The chef is notified of any dietary changes for the residents. Food is transported in hotboxes to the dining rooms where it is served from a bain-marie. The upstairs dining area has a kitchenette. Special diets are plated and labelled. The fridge and freezer have visual temperatures, which are recorded daily. The facility fridges temperatures are monitored (records sighted). Temperature of food on delivery is recorded.</p> <p>Feedback on the service and meals is by direct verbal feedback, residents' meetings and surveys. The chef and care centre manager meet weekly to share any further feedback and to maintain close communication. Residents and family members interviewed were complimentary of the food service provided and reported that individual preferences are well catered.</p> <p>There is a downstairs dining area for rest home residents in serviced apartments.</p> <p>Staff working in the kitchen have food handling certificates and receive ongoing training. The food plan which had 100% acceptance expires 5 February 2020.</p>
<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>	<p>FA</p>	<p>In all six care plans sampled, care plans included all interventions to support current needs (five long-term care plans and one respite care plan). Residents interviewed stated their needs are being met. Relatives interviewed stated their relatives receive care within a timely manner and they are kept informed of any health changes, GP visits and care plan reviews.</p> <p>Dressing supplies are available, and a treatment room is stocked for use. Contenance products are available and resident files included continence management. Specialist continence advice is available as needed and this could be described. Contenance management in-services and wound management in-service have been provided.</p> <p>Wound assessment and ongoing assessment and treatment plans are in place for six residents with ten wounds. Those reviewed included one skin tear, seven lesions and a diabetic ulcer. There were no pressure injuries on the day of audit. The wound nurse specialist or the DHB surgical unit had input into the wound care for four of the six residents. All wounds had been reviewed in appropriate timeframes.</p> <p>Residents' weights are recorded on admission and monthly thereafter. Where a risk is identified, care plans identified increase monitoring of weight and implementation of food/fluid charts. There were consistent records kept around weight documentation.</p> <p>Monitoring forms were in use to monitor a resident's progress such as vital signs, neurological observations, blood sugars, food and fluid and behaviour charts.</p>
<p>Standard 1.3.7: Planned Activities</p>	<p>FA</p>	<p>The service employs two qualified diversional therapists (both have first aid certificates) for a combined total of 56 hours per week, covering seven days. All long-term files sampled included activity plans (the respite resident file included an activities report). Monthly progress notes are written. There is evidence of an implemented activities</p>

<p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>programme available to all residents. Activities are planned that are appropriate to the functional capabilities of residents, taking into consideration physical and cognitive abilities and sensory impairment. One-on-one time is spent with hospital level residents or those who choose not to participate in the groups and includes reading/chats and pamper sessions. Residents go out to regular community events. Special events, festive occasions and birthdays are celebrated. There are church services six times a month. Kindergarten and intermediate school children visit. There are van outings and visits by entertainers weekly. The physiotherapist takes an exercise class monthly and there is a massage chair available (under supervision). Residents in the serviced apartments who are receiving rest home level care can choose to attend either the village programme or the care centre programme. There is integration between the village and the care centre and village residents volunteer and assist with activities. Residents interviewed reported positively about the activity programme.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>There was evidence in files sampled of resident and family (where appropriate) involvement in MDT reviews. Three long-term care plans reviewed that had been with the service longer than six months had at least six-monthly documented evaluations. There were short-term care plans to focus on acute and short-term issues. These are reviewed daily by a registered nurse. All initial care plans are evaluated by the registered nurses within three weeks of admission.</p>
<p>Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>There are two current building WOFs that are prominently displayed. As it was originally a staged opening, there are two building WOFs, one with the expiry date of 20 January 2020 the other expires on 27 January 2020. There is a reactive maintenance programme and planned maintenance programme in place.</p> <p>The internal and external communal areas are accessible to residents and provide seating and shade.</p> <p>Caregivers interviewed stated they have sufficient equipment available to deliver cares as directed in care plans.</p>
<p>Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed</p>	<p>FA</p>	<p>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 into the VCare electronic system. The infection control coordinator (clinical nurse leader) provides infection control data, trends and relevant information to the infection control committee and clinical/quality meetings. Monthly zoom meetings are held for all infection control coordinators with the infection control manager at head office. 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</p>

objectives, priorities, and methods that have been specified in the infection control programme.		the infection control coordinator and used to identify areas for improvement. Infection control audits are completed, and corrective actions are signed off. There has been one norovirus outbreak in February 2019. A notification to the public health and case logs were sighted. A debrief meeting was held for all staff with improvements discussed and implemented.
Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised.	FA	There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. A registered nurse is the restraint coordinator with a job description that defines the role and responsibilities. The policy identifies that restraint is used as a last resort. There were no residents requiring the use of a restraint and no residents using an enabler at the time of audit. Restraint minimisation is discussed at clinical meetings and care staff complete annual restraint competencies and training.



## Specific results for criterion where corrective actions are required

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

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

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

No data to display
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## Specific results for criterion where a continuous improvement has been recorded

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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
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End of the report.