

Summerset Care Limited - Summerset on Summerhill

Introduction

This report records the results of a Certification 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 on Summerhill
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 26 February 2015 End date: 27 February 2015
Proposed changes to current services (if any):	Two beds have been assessed as suitable for rest home or hospital level care.
Total beds occupied across all premises included in the audit on the first day of the audit:	42

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 on Summerhill provides rest home and hospital level care for up to 43 residents. This includes the addition of two rooms assessed as suitable for rest home or hospital level care. On the day of the audit there were 42 residents. The service is managed by a village manager and a nurse manager. The residents and relatives interviewed spoke positively about the care and support provided.

This certification audit was conducted against 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 a general practitioner.

The village manager is appropriately qualified and experienced and is supported by a nurse manager (registered nurse) who oversees the care centre. There are quality systems and processes being implemented. The service has been actively working on reducing the incidence of falls, reducing turnover of staff and improving communication with service users. An induction and in-service training programme is in place to provide staff with appropriate knowledge and skills to deliver care.

The service is commended for achieving a continued improvement rating around their infection surveillance programme.

Improvements are required around documenting timeframes, residents' care plans and interventions and medication management.

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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Staff demonstrate an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for the residents. Residents are treated with dignity and respect. Written information regarding consumers' rights is provided to residents and families during the admission process. Residents' cultural, spiritual and individual values and beliefs are assessed on admission. A Maori health plan is incorporated into the delivery of services for Maori residents. There is evidence that residents and family are kept informed. A system for managing complaints is in place. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

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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Services are planned, coordinated, and are appropriate to the needs of the residents. Quality and risk management processes are maintained, reflecting the principals of continuous quality improvement. Strategic plans and quality goals are documented for the service. Corrective action plans are implemented where opportunities for improvement are identified. A risk management programme is in place, which includes a risk management plan, incident and accident reporting, and health and safety processes. Adverse, unplanned and untoward events are documented by staff. Human resources are managed in accordance with good employment practice, meeting legislative requirements. A comprehensive orientation programme is in place for new staff. An

education and training programme for staff is embedded into practice. Registered nursing cover is provided twenty four hours a day, seven days a week. There are adequate numbers of staff on duty to ensure residents are safe. The residents' files are appropriate to the service type.

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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The service has assessment processes and residents needs were assessed prior to entry. There is a well-developed information pack available for residents and families/whānau at entry. Assessments, resident centred care plans and evaluations were completed by the registered nurses within the required timeframes. Risk assessment tools and monitoring forms were available. Resident centred care plans were individualised. There are improvements required around aspects of care planning and implementation of interventions.

A diversional therapist and activity coordinator plan and implement an integrated activity programme. The activities meet the individual recreational needs and preferences of the consumer groups. There are outings into the community and visiting entertainers.

Staff responsible for the administration of medications complete annual medication competencies and education. The general practitioner reviews the medication charts three monthly. There are improvements required around administration, medication documentation and prescribing.

The food service is contracted and 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.
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Emergency systems are in place in the event of a fire or external disaster.

There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances. The building has a current warrant of fitness. Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. Documented systems are in place for essential, emergency and security services. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. Resident bedrooms are spacious and personalised with access to ensuite.

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.
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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.

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.

All standards applicable to this service fully attained with some standards exceeded.

The infection control programme was appropriate for the size and complexity of the service. The infection control coordinator (RN) is responsible for coordinating/providing education and training for staff. The infection control coordinator has attended induction and organisational training. The infection control manual outlined the scope of the programme and included a comprehensive range of policies and guidelines. The infection control coordinator used the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This included audits of the facility and surveillance of infection control events and infections. The service engaged 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)
Standards	1	45	0	2	2	0	0
Criteria	1	96	0	2	2	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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Code of Health and Disability Consumers' Rights (the Code) poster is displayed in a visible location in English and in Maori. Policy relating to the Code is implemented and staff can describe how the Code is incorporated in their everyday delivery of care. Staff receive training about the Code during their induction to the service, which continues through in-service training. Interviews with care staff (three caregivers, two registered nurses (RNs), and two activities staff) reflected their understanding of the key principles of the Code.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. Written general and specific consents were evident in the seven resident files sampled. Caregivers interviewed confirm consent is obtained when delivering cares. Resuscitation orders for competent residents were appropriately signed. The service acknowledges the resident is for resuscitation in the absence of a signed directive by the resident. The general practitioner (GP) discusses resuscitation with families/EPOA where the resident was deemed incompetent to make a decision.</p> <p>Discussion with family members identifies that the service actively involves them in decisions that affect their relative's lives. Seven admission agreements sighted were signed within the required timeframe.</p>

give informed consent.		
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Information on advocacy services through the Health and Disability Commissioner's (HDC) Office is included in the resident information pack that is provided to residents and their family on admission. Interviews with family confirm their understanding of the availability of advocacy services. Staff receive education and training on the role of advocacy services.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	The service has an open visiting policy. Residents may have visitors of their choice at any time. The service encourages the residents to maintain their relationships with their friends, and community groups by continuing to attend functions and events, and providing assistance to ensure that they are able to participate in as much as they can safely and desire to do.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The service has a complaints policy that describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission. Interviews with residents and family members confirmed their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints. There is an electronic complaints register that includes verbal and written complaints and evidence to confirm that complaints are being managed in a timely manner including acknowledgement, investigation, time lines, and corrective actions when required and resolutions. No formal complaints were received in 2014. One complaint received in 2015 (year to date) was managed within the required time frames in an appropriate manner.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Details relating to the Code and the Health and Disability Advocacy Service are included in the resident information pack that is provided to new residents and their family. The registered nurse discusses aspects of the Code with residents and their family on admission. Discussions relating to the Code are also held during the annual resident/family meetings. All seven residents (four rest home level and three hospital level) and five families (two rest home level and three hospital level)

		interviewed report the residents' rights are being upheld by the service.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The service ensures that the residents' right to privacy and dignity is recognised and respected at all times. The residents' personal belongings are used to decorate their rooms. All rooms are single occupancy with a selection of rooms with full ensuite. Privacy signage is in place on toilet and shower doors. The caregivers interviewed report that they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas. They report that they facilitate the residents' independence by encouraging them to be as active as possible.</p> <p>All of the families interviewed report that their family member's privacy is respected.</p> <p>Guidelines on abuse and neglect are documented in policy. Staff receive education and training on abuse and neglect. Any instances of suspected abuse and/or neglect are dealt with in an appropriate manner by the village manager.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Maori are valued and fostered within the service. The village manager, nurse manager and staff value and encourage active participation and input from the family/whanau in the day-to-day care of the resident. There was one resident living at the facility whose family is Maori, and cultural values and beliefs are being met by the service, evidenced in an interview.</p> <p>Maori consultation is available through links with Maori organisations within the community. Several care staff identify as Maori. Staff receive education on cultural awareness during their induction to the service and as a regular in-service topic.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and</p>	FA	<p>The service identifies the residents' personal needs and desires from the time of admission. This is achieved with the resident, family and/or their representative. The service is committed to ensuring that each resident remains a person, even in a state of mental decline. Beliefs and values are discussed and incorporated into the care plan, sighted in all seven care plans reviewed. All residents and families interviewed confirmed they were involved in developing the resident's plan of care, which included the identification of individual values and beliefs.</p>

respect their ethnic, cultural, spiritual values, and beliefs.		
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	The professional boundaries policy is discussed and signed by the new employee during their induction to the service. Professional boundaries are also defined in job descriptions. Interviews with all care staff confirm their understanding of professional boundaries including the boundaries of the caregivers' role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings, and performance management if there is infringement with the person concerned.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	<p>Summerset systems promote and encourage good practice. A registered nurse is available 24 hours a day, seven days a week. A general practitioner (GP) visits the facility two times a week. Residents are reviewed by the general practitioner (GP) every three months at a minimum.</p> <p>The nurse manager/RN has a teaching background. Education and training for staff is provided every week. Attendance rates are high. If a training session is missed, the RN provides one-on-one education with the individual. A range of competency assessments are completed in addition to in-service training. Reminders are provided in writing (on Time Target) to remind staff when competency assessments are due. The caregivers interviewed report that the education and training sessions are very informative and helpful.</p> <p>The quality management programme for 2015 includes clinical key performance indicators with upper and lower control limits based on historical internal and external aged care data. Collated data is trended for 12 months. Strategic plans have been developed for falls and skin tears (2014/2015) and pressure areas (2015). These strategic plans reflect objectives and dates for completion. Staff interviews confirm their heightened areas of these targeted areas for improvement. The nurse manager provided specific examples of strategies implemented that have reduced the incidence of adverse events.</p> <p>Residents meetings are held three-monthly. In addition to residents meetings, the village manager meets with friends and family every three months. These meetings enhance communication and include written information via power point presentations. Outcomes resulting from the meetings have included implementing a new product for thickening fluids. Families interviewed are very satisfied with the services received, which were confirmed in the most recent resident satisfaction survey.</p> <p>The clinical quality manager has implemented a 'best practice sheet' which is fully embedded into practice. This tool has improved compliance in documenting the completion of quality and risk activities.</p> <p>The service receives support from the District Health Board (DHB) which includes specialist visits. Physiotherapy services are available are needed. A podiatrist is available six-weekly and a hairdresser is available at least once</p>

		<p>a week. A van is available for regular outings.</p> <p>The GP interviewed is satisfied with the care that is being provided by the service.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>An open disclosure policy describes ways that information is provided to residents and families. The admission pack includes a comprehensive range of information regarding the scope of service provided to the resident and their family on entry to the service and any items they have to pay that is not covered by the agreement. Regular contact is maintained with family including if an incident or care/ health issues arises. Five family interviewed stated they were well informed. Ten incident/accident forms were reviewed and all identified that the next of kin were contacted.</p> <p>Residents' meetings are held three monthly. The village manager also regularly meets with family and friends three monthly.</p> <p>The service has policies and procedures available for access to DHB interpreter services and residents. The information pack is available in large print and can be read to residents.</p> <p>Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so.</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>	FA	<p>Summerset on Summerhill provides rest home and hospital level care for up to 43 residents. This includes the addition of two rooms assessed as suitable for rest home or hospital level care. On the day of the audit there were 42 residents - 12 rest home level and 30 hospital level. There is a retirement village attached as part of the complex with overall management of the site provided by a village manager.</p> <p>A strategic plan is in place for the organisation. An annual quality plan for the service is linked to the strategic plan and includes annual goals and objectives. Quality is overseen by the organisation's clinical quality manager.</p> <p>The village manager has been employed by Summerset for 18 months. She has a business management background. The nurse manager is a registered nurse employed to oversee the running of the rest home and hospital. She has been working at this facility for two years and has worked in aged care for five years.</p> <p>The village manager and nurse manager have maintained more than eight hours of professional development activities related to managing an aged care facility.</p> <p>Summerset has robust quality and risk management systems implemented across all its facilities.</p> <p>All Summerset villages are supported by an Operations Manager who visit on a six weekly cycle. Clinical support is provided by the clinical team, who ensure that six weekly visits are made to all villages to provide advice, support and mentoring to all staff including nurse management. The Village Manager provides a documented</p>

		<p>monthly report to the Operations Manager.</p> <p>There are robust reporting systems and data capture includes incidents and accidents, infection control and internal audit results are entered into SWAY on a monthly basis. All data is graphed, trended and reviewed by Head Office. Monthly follow ups by the Clinical Quality Manager with each care centre occur when outcomes are outside parameters or trends.</p> <p>The organisation has established a Clinical Quality Committee. This committee meets monthly with the aim of reviewing history and looking forward. All results are reported to the Clinical Quality Committee, the Executive Team and Board as part of monthly and quarterly reporting.</p> <p>Benchmarking of some key indicators with another NZ provider has also commenced.</p> <p>Summerset on Summerhill is part of the lower North Island group that includes six facilities. Monthly teleconferences occur with Village Managers and Nurse Managers and individual forums are held every six months for both.</p> <p>Each year Village Managers complete a site specific, comprehensive Business Plan for their village. This is presented to an Executive Member for sign off and once completed the village manager shares the content with their management staff. This is reviewed monthly by the Operations Manager, and reported against three monthly in the Summerset Board report. Goals are objective, site specific and based on continued growth and improvement in performance and service delivery.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>The village manager and the nurse manager do not take leave at the same time and cover each other's absence. Furthermore, a senior RN or a 'roving' RN employed by the organisation is available to cover the nurse manager's clinical responsibilities in her absence.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p>	FA	<p>Summerset on Summerhill has a well-established quality and risk management system. Interviews with staff and review of meeting minutes/quality action forms/toolbox demonstrate a culture of quality improvements. Quality and Risk performance is reported at all meetings. Policies and procedures reflect evidence of regular reviews as per the document control schedule. New and/or revised policies are made available for staff to read and sign that</p>

<p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>they have read and understand the changes. Village managers and nurse managers are held accountable for their implementation. The monthly collating of quality and risk data includes (but is not limited to) residents' falls, infection rates, and pressure areas. Data is collated and benchmarked against other Summerset facilities to identify trends. A resident satisfaction survey is conducted each year. Results for 2014 reflect 93% resident satisfaction with the services received. An annual internal audit schedule reflects audits are being completed as per the schedule. Corrective actions are developed where opportunities for improvements are identified and are signed off by the village manager or nurse manager when completed. Staff are kept informed of audit findings and quality initiatives. A falls reduction strategic plan was sighted for the service. Sensor mats and physiotherapy services are utilised. The health and safety programme is overseen by a health and safety team that meets three-monthly. Processes are in place for accident and incident reporting, injury prevention and management, workplace inspections, hazard management and first aid.</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>The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. The reporting system is integrated into the quality and risk management programme. Once incidents and accidents are reported the immediate actions taken are documented on incident forms. The incidents forms are then reviewed and investigated by the nurse manager. If risks are identified these are processed as hazards.</p> <p>Discussions with the village manager and nurse manager have confirmed their awareness of statutory requirements in relation to essential notification.</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</p>	<p>FA</p>	<p>There are job descriptions available for all relevant positions that describe staff roles, responsibilities and accountabilities. The practising certificates of nurses are current. The service also maintains copies of other visiting practitioners practising certificates. Eight staff files were reviewed (three caregivers and four registered nurses and one activities staff). Evidence of signed employment contracts, job descriptions, orientation, and training was available for sighting. Annual performance appraisals for staff are being done. Newly appointed staff complete an orientation that is specific to their job duties. Interviews with care staff described the orientation programme that includes a period of supervision.</p> <p>The service has a training policy and schedule for in-service education. The in service schedule is implemented and attendance is recorded. For those staff members who are unable to attend education, an RN provides one-on-one training. All staff complete a range of competency assessments. Education is well supported for all staff</p>

legislation.		<p>at Summerset on Summerhill. Competencies are completed for key nursing skills and Registered Nurses regularly access training including sessions externally run e.g. MidCentral DHB sessions. RN's can choose two clinical trainings of their choice per annum and these are funded by the organisation. This is additional to the annual training scheduled for RN's and developed by the organisation. Careerforce – It is a Summerset requirement of employment that all staff are enrolled after the 90 day trial period on Careerforce and they are then required to complete within 9 months. Summerset on Summerhill has all but one staff member trained at Level 2 and eight staff have been enrolled to undertake Level 3. NETP students – This year Summerset on Summerhill secured a Ministry of Health funded new graduate under the MidCentral DHB NETP programme.</p> <p>PDRP – Summerset on Summerhill currently has 9 RN's. Two are fully competent, three are currently enrolled and the remaining three are casual RN's. Completed education is captured on electronic spread sheet, easily identifying attendance and capturing those 'non-attendeers.' Records are kept of staff that have read and signed sessions. Competencies are completed for key nursing skills. Registered nurses regularly access training including sessions that are externally run. All Summerset on Summerhill RN's will be InterRAI trained by the end of 2015.</p> <p>Summerset has introduced leadership development of qualified staff by a weekly funded teleconferencing project. This allows RN's to interact with other RN's within the organisation and share their experiences of how to manage clinical situations, particularly ideas regarding the leadership of unregistered staff. This has been well received once we overcame the technical requirements.</p> <p>The book club is a new initiative introduced as a means of alternative learning. Books are chosen by topic, the staff are surveyed prior to reading the book to assess their knowledge on the specific topic, currently Alzheimer's and Parkinson's. After the book has been read staff get together and share their thoughts on the content of the book and what they either found interesting or not. Plans are already afoot to introduce 'movie nights' to assist with education.</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>	FA	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. An RN is scheduled 24 hours a day, seven days a week. Staff reported that staffing levels and the skill mix was appropriate and safe. All families interviewed advised that they felt there was sufficient staffing. The roster is able to be changed in response to resident acuity.</p>
<p>Standard 1.2.9: Consumer Information</p>	PA Low	<p>The residents' files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. An initial support plan is also</p>

<p>Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>		<p>developed in this time. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access by being held in a secure room. Archived records are secure in separate locked and inaccessible areas.</p> <p>Residents' files demonstrate service integration. Entries are legible, dated and signed by the relevant caregiver or nurse, including designation. Missing is evidence of the time of entry in the progress notes.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>All residents have a needs assessment completed prior to entry that identifies the level of care required. The nurse manager screens all potential enquiries to ensure the service can meet the required level of care and specific needs of the resident. There is currently a waiting list. The one district health board (DHB) funded respite bed is booked in advance.</p> <p>Residents interviewed (four rest home and four hospital) and relatives interviewed (two rest home and three hospital) stated that they received sufficient information on admission and discussion was held regarding the admission agreement. There is a well-developed information pack, which includes advocacy and health and disability information.</p> <p>The admission agreement reviewed aligns with a) -k) of the ARC contract. It includes information about when a resident may be required to leave the facility. Exclusions from the service are included in the admission agreement.</p> <p>The information provided at entry includes examples of how services can be accessed that are not included in the agreement.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>There is an exit discharge and transfer policy that describes guidelines for death, discharge, transfer, documentation and follow-up. This directs staff to the appropriate documentation. All relevant information is documented and communicated to the receiving health provider or service. Follow up occurs to check that the resident is settled or, in the case of death, communication with the family is made.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive</p>	<p>PA Moderate</p>	<p>RNs are responsible for the administration of medications in the rest home and hospital wings. Senior caregivers also complete medication competencies for the checking of medications. Medication competencies and education has been completed annually. All medications were checked on delivery with any discrepancies fed back to the</p>

<p>medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>supplying pharmacy. Standing orders were current. There were no rest home residents self-medicating.</p> <p>There are improvements required to ensure the medication management system meets recognised standards and guidelines in accordance with the Medicines Care Guide for Residential Aged Care 2011.</p> <p>Fourteen resident medication charts sampled were identified with photographs and allergy status and identified that the GP had reviewed the medication chart three monthly.</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>FA</p>	<p>The provision of meals on-site is contracted. There is an eight week rotating menu approved by the dietitian. There are alternative meal options available and resident likes/dislikes and preferences are known and accommodated. Special diets provided include vegetarian and mouli meals. The cook receives a dietary profile for each resident. Specialised crockery and utensils were available to promote independence with meals.</p> <p>The kitchen equipment items have been tested and tagged. The fridge, freezer and dishwasher have daily temperatures recorded. End cooked food temperatures were recorded twice daily. Cleaning schedules were maintained. Staff were observed wearing correct personal protective clothing. Staff working in the kitchen have food handling certificates and have undergone chemical safety training.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>The reason for declining service entry to residents is due to bed unavailability. When this occurs the resident or family/ whanau are referred to the original referral agent for further information.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded</p>	<p>FA</p>	<p>The initial support plan is developed with information from the initial assessment. Clinical risk assessments include continence, safe handling, falls risk, pressure area risk, mini nutritional assessment, and cultural needs assessment, pain assessment, and challenging behaviour and wound assessments (link 1.3.5.2 and 1.3.6.1). These are available for use as applicable. Risk assessments were completed on admission and reviewed at least six monthly or earlier due to health changes as sighted in the resident files sampled. Risk assessment tools are used to identify the required needs and interventions to meet resident goals.</p>

in a timely manner.		
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>Resident centred care plans describe the individual support and interventions required to meet the resident goals. Care plans reviewed demonstrated service integration and include input from allied health practitioners. There is an improvement required around care plan documentation to describe the resident supports.</p> <p>Care plans were updated for any changes to resident health status. There is documented evidence (care plan consultation record) of resident/family/whanau involvement in the care planning process. Residents/relatives interviewed confirmed they participate in the care planning process.</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>PA Low</p>	<p>Residents interviewed state their needs are being met. Families interviewed confirm they are notified of any change to their relative's health. There is documented evidence of communication with families on the family consultation record and emails held on file. When a resident's condition alters, the registered nurses initiate a review and if required, GP or nurse specialist consultation.</p> <p>Dressing supplies are available and a treatment room is stocked for use. 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 and wound advice is available as needed.</p> <p>There were initial wound assessments and on-going assessment and treatment plans in place for minor wounds, three chronic ulcers and two pressure areas (heels). There is evidence of district nurse and wound nurse involvement in wound management.</p> <p>Improvements around interventions are required.</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>	<p>FA</p>	<p>There is an activity coordinator who has been with the service nine months and currently progressing through the diversional therapy (DT) course. A DT commenced one week ago and has undergone orientation. The combined total of activity hours are 43 per week over seven days.</p> <p>The programme is integrated for rest home and hospital residents. The programme is planned a month in advance and includes activities coordinated by the activity team, entertainers, themes, cultural days, community events, pet therapy, outings and van drives and men's group. Three volunteers assist with the activities. One-on-one contact is made with residents who are unable or choose not to participate in group activities. Church services are held on-site.</p> <p>The activity assessment is completed in consultation with the family on admission. The activity team are involved in the MDT reviews. Activity plans and care plans are reviewed at the same time.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>There is evidence of resident and family involvement in the review of resident centred care plans. Written evaluations were completed six monthly or earlier for resident health changes in files sampled. Resident goals were identified as met or not met. There is evidence of multidisciplinary (MDT) team involvement in the reviews. The GP completes three monthly reviews.</p> <p>All initial care plans were evaluated by the registered nurses within three weeks of admission.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>The service provided examples of where a resident's condition had changed and the resident was reassessed for a higher level of care.</p> <p>Discussions with the nurse manager identified that the service has access to (but not limited to); speech language therapist, community physiotherapist, wound care nurse, needs assessment service, social worker, geriatrician, hospice, community mental health nurse and nurse specialists. This was evidenced in the files reviewed.</p> <p>The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated</p>	FA	<p>Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Material safety data sheets and product information was readily accessible for staff. Chemical bottles sighted have correct manufacturer labels. Chemicals were stored in a locked chemical cupboard and safely in the kitchen and laundry areas. A chemical spills kit is available. Personal protective clothing was available for staff and seen to be worn by staff when carrying out their duties on the day of audit.</p>

during service delivery.		
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building has a current building warrant of fitness that expires on 24 July 2015. There is a full time property manager who is available on call for facility matters. Planned and reactive maintenance systems are in place and maintenance requests are generated through the on-line system using the Sway (Summerset way) programme. All electrical equipment has been tested and tagged. Clinical equipment has had functional checks/calibration annually. Hot water temperatures (sighted) are tested monthly and maintained between 42-45 degrees Celsius. Preferred contractors are available 24/7.</p> <p>Corridors are wide in all areas to allow residents to pass each other safely. There is safe access to all communal areas and outdoor areas. There is outdoor seating and shade sail. There were no smoking residents on the day of audit.</p> <p>The caregivers and registered nurses (interviewed) state they have all the equipment required to provide the care documented in the care plans. The following equipment is available: electric beds, ultra-low beds, sensor mats, standing and lifting hoists, wheel-on scales, chair scales, hospital lounge chairs and mobility aids.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>Visual inspection evidences toilet and shower facilities are of an appropriate design to meet the needs of the residents. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. All bedrooms have either a shared or single ensuite. There are communal toilets located near the lounge/dining rooms. Communal toilet facilities have a system that indicates if it is engaged or vacant.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate</p>	FA	<p>There is adequate room to safely manoeuvre mobility aids and transferring equipment such as hoists in the resident bedrooms. The doors are wide enough for ambulance trolley access. Residents and families are encouraged to personalize their rooms as viewed on the day of audit. There is a mix of carpet and vinyl flooring in the bedrooms. Two additional dual purpose bedrooms (approved in January 2014 by HealthCERT) were viewed on the day of audit. The size of both bedrooms can accommodate hospital level of care. There is a shared</p>

personal space/bed areas appropriate to the consumer group and setting.		ensuite.
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	Communal areas within the facility include a separate dining room, large main lounge and smaller lounges at the end of two wings. A family room has tea making facilities. The communal areas are easily accessible for residents. Activities take place in the lounges throughout the facility.
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. All linen and personal clothing was laundered onsite. The laundry has a dirty to clean work flow. Care staff operate the laundry on night shift. There is dedicated housekeeping staff. Cleaning trolleys were well equipped and kept in designated locked cupboards. Residents and family interviewed report satisfaction with the cleaning and laundry service. Internal audits monitor the effectiveness of the cleaning and laundry processes.
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security</p>	FA	<p>Emergency and disaster policies and procedures are documented for the service. An approved the fire evacuation plan is in place. Fire evacuation drills occur every six months. The orientation programme and annual education and training programme include mandatory attendance at fire and security training. Staff interviews confirm their understanding of emergency procedures. Required fire equipment was sighted on the day of audit. Fire equipment has been checked within required timeframes.</p> <p>A civil defence plan is documented for the service. There are adequate supplies readily available in the event of a</p>

situations.		<p>civil defence emergency including food, water, blankets and gas cooking.</p> <p>A call bell system is in place. Residents were observed in their rooms with their call bell alarms in close proximity. There is a minimum of one person who available 24 hours a day, seven days a week with a current first aid/CPR certificate.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>Visual inspection evidences that the residents were provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The infection control programme was appropriate for the size and complexity of the service and is reviewed annually. The IC programme is set out annually from head office. A RN is the infection control coordinator with defined responsibilities outlined in the job description. The facility meetings also include a discussion of infection control matters.</p> <p>There are adequate hand washing facilities and hand sanitisers throughout the facility. Visitors are requested not to visit if they have been unwell. Resident education occurs on an individual basis as and when required. Influenza vaccines are offered to residents and staff.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and</p>	FA	<p>The infection control (IC) committee is made up of a cross section of staff from areas of the service including; (but not limited to) the nurse manager, RN, caregiver, housekeeper and maintenance. The committee meet three monthly.</p> <p>The facility also had access to an infection control nurse specialist, public health, GP's and expertise within the organisation. The facility had developed links with the GP's, local laboratory, the infection control and public</p>

information resources to implement the infection control programme and meet the needs of the organisation.		health departments at the local DHB and pharmacist.
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	There are comprehensive infection control policies that are current and reflected the Infection Control Standard SNZ HB 8134:2008, legislation and good practice. These are across the Summerset organisation and are regularly reviewed. The infection control policies link to other documentation and cross reference where appropriate.
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	The infection control coordinator has been in the role two months and has completed IC induction through the organisation. Annual IC training is provided for IC coordinators. The IC coordinator links into regional district health board training as available. The infection control coordinator is responsible for providing IC education for orientating staff. Infection control education for all staff is included in the company education planner. Additional information and education occurs at handovers. Resident education was expected to occur as part of providing daily cares. Care plans can include ways to assist staff in ensuring this occurs.
Standard 3.5: Surveillance	CI	The infection control policy includes a surveillance policy and definitions for infections. A monthly data base of infections are summarised and graphed. The infection control coordinator provides reports to the head office,

<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>quality meetings and staff meetings. Infection control data entered on line is reviewed by the Somerset Clinical Quality Manager monthly and any areas for improvement are highlighted for follow up and corrective action. Infection control audits were completed as scheduled.</p> <p>The facility is benchmarked against other Somerset facilities of similar size and results are fed back to the infection control coordinator to identify areas for improvement. Strategies for reducing urinary tract infections of include regular toileting, increased fluids and hydration regime, jellies and ice blocks for residents. Plentiful fluids were observed to be readily available on the day of 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>There are policies around restraints and enablers. The service currently has ten residents assessed as requiring the use of restraint (bed rails and lap belts) and six requiring enablers (bedrails only). Their care plans are up to date and provide the basis of factual information in assessing the risks of safety and the need for restraint. On-going consultation with the resident and family/whanau is also identified. Residents voluntarily request and consent to enabler use.</p> <p>Staff receive training around restraint minimisation that includes annual competency assessments.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>A restraint approval process and a job description for the restraint coordinator are in place. The restraint coordinator role is delegated to the nurse manager. All staff are required to attend restraint minimisation training annually.</p>
<p>Standard 2.2.2: Assessment</p>	<p>FA</p>	<p>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. A restraint assessment tool meets the requirements of the standard. Two hospital level residents' files where restraint was</p>

Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.		being used were selected for review. Each file included a restraint assessment and consent form that was signed by the resident's family. Restraint use is linked to the resident's care plan and is regularly reviewed.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	A restraint register is in place. The register identifies the residents that are using a restraint, and the type(s) of restraint used. The restraint assessment identified that restraint is being used only as a last resort. The restraint assessment and on-going evaluation of restraint use process includes reviewing the frequency of monitoring residents while on restraint. Monitoring forms are completed when the restraint is put on and when it is taken off.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	Restraint use is reviewed three monthly by the restraint committee during restraint meetings. The review process includes discussing whether continued use of restraint is indicated.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The restraint programme, including reviewing policies and procedures and staff education is evaluated annually by the national quality manager and the national education manager.

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 1.2.9.1 Information is entered into the consumer information management system in an accurate and timely manner, appropriate to the service type and setting.	PA Low	Residents are assessed within 24 hours of admission. Documentation includes progress notes that are dated and signed by the caregivers and the RNs. Staff interviews confirm that they are aware they must also record the time of entry but they report that that forget to do this.	Progress notes do not reflect the time of entry.	Ensure progress notes include the time of entry. 90 days
Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing,	PA Moderate	Six of fourteen medication charts and signing sheets met legislative requirements. There were standing orders in place for each resident dated July 2014. Regular	(i) There was transcribing of medications on eight of 14 non-packaged/as required medication signing sheets. (ii) Three medications administered were not on the standing orders or prescribed on the medication chart. (iii) There was no evidence of medication reconciliation for a regular respite care resident. The medication	Ensure the practice of administration, reconciliation, and prescribing of medication meet the legislative

dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.		medications are checked on delivery against the medication charts. Improvements are required around aspects of medication management.	chart had not been reviewed by the GP since July 2014. (iv) Each medication prescribed on eight of 14 medication charts have not been individually dated.	requirements and avoid transcribing. 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	The care plan and interventions describe the required support to meet the resident needs in one rest home file and two hospital files sampled. An improvement in care plan documentation is required in the respite file and three hospital files sampled.	Care plans did not describe supports required for (i) respite care resident with an enabler in use. (ii) One hospital resident on insulin did not management of hypoglycaemia/hyperglycaemia documented in the care plan, (iii) one hospital resident recently admitted had no alert in the care plan for positive MRSA noted in the discharge summary and GP medical notes. A history of falls had not been identified on the initial support plan. (iv) challenging behaviours identified through assessment and behaviour monitoring for one hospital resident has not been documented in the care plan.	Ensure care plans describe the required supports/interventions to meet the needs of the residents. 90 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 Low	When a residents condition changes, the RN initiates a review and if required a GP or nurse specialist consultation. Relatives interviewed state their relatives needs are met and they are kept informed of any health changes. Interventions identified for the rest home respite resident and one hospital resident have not been implemented.	(i) There was no weight recorded on admission for the respite care resident. There was no falls risk assessment completed. (ii) A weekly weigh has not been commenced as per care plan for one hospital resident.	Ensure risk assessments are completed and interventions are implemented. 90 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 3.5.7</p> <p>Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>	CI	<p>The facility is benchmarked against other Somerset facilities of similar size and results are fed back to the infection control coordinator to identify areas for improvement. Strategies for reducing urinary tract infections of include regular toileting, increased fluids and hydration regime, jellies and ice blocks for residents.</p>	<p>Somerset have introduced a new infection control surveillance programme to improve the robustness of data collection. This was fully implemented with this new programme using data collection sheets based on best practice from an external infection control specialist. Analysis of infection data occurs monthly and includes opportunities for improvement. Monthly reports are also completed from benchmarking analysis. Monthly infection surveillance includes whether resolved, trends and quality initiatives. The 2014 analysis was conducted. The clinical/quality manager for the organisation reviews monthly infection rates and supports the facility to develop action plans in response to infection rates.</p>

End of the report.