

Summerset Care Limited - Summerset By the Sea

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 By the Sea
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 27 June 2016 End date: 28 June 2016
Proposed changes to current services (if any):	
Total beds occupied across all premises included in the audit on the first day of the audit:	28

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 by the Sea is part of the Summerset Group and provides rest home and hospital (medical and geriatric) level care for up to 40 residents. On the days of audit, there were 28 residents.

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, interviews with residents, family, management, staff and a general practitioner.

The nurse manager is appropriately qualified and experienced, and supported by registered nursing staff. There are quality systems and processes established. Feedback from the residents and families was very positive about the care and services provided. An induction and in-service training programme is in place to provide staff with appropriate knowledge and skills to deliver care.

This certification audit identified that improvements are required in relation to privacy locks for communal toilets/showers, communicating quality results with staff, corrective action plans, hair protection while preparing food, and restraint evaluations.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Some standards applicable to this service partially attained and of low risk.
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Information about services provided is readily available to residents and families. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is evident on noticeboards. Policies are implemented to support rights such as privacy, dignity, abuse and neglect, culture, values and beliefs, complaints, advocacy and informed consent. Care planning accommodates individual choices of residents and/or their family/whānau. Residents are encouraged to maintain links with the community. Complaints processes are implemented, and complaints and concerns are managed appropriately.

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 appropriate to the needs of the residents. A nurse manager is responsible for the day-to-day operations of the care facility. Quality and risk management processes are established. Strategic plans and quality goals are documented for the service. A risk management programme is in place, which includes a risk management plan, incident and accident reporting, and health and safety processes. Staff document adverse, unplanned and untoward events. The health and safety programme meets current legislative requirements. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. A staff education and training programme 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 low risk.</p>
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There is a comprehensive admission package available prior to or on entry to the service. The registered nurses are responsible for each stage of service provision. Care plans viewed in resident records demonstrated service integration and were reviewed at least six monthly. Resident files included medical notes by the contracted GPs and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and senior caregivers responsible for administration of medicines complete education and medication competencies. The medicine charts reviewed meet prescribing requirements and were reviewed at least three monthly.

The activities programme meets the individual recreational, physical, cultural and cognitive needs of residents. Residents and families report satisfaction with the activities programme.

Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on site. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

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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There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Chemicals are stored safely throughout the facility. The building holds a current warrant of fitness. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. Resident bedrooms are personalised with access to individual ensuites or communal facilities. Documented policies and procedures for the cleaning and laundry services are implemented. Systems are in place for essential, emergency and security services.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Some standards applicable to this service partially attained and of low risk.
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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

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinators (a registered nurse and enrolled nurse) are responsible for coordinating education and training for staff. The infection control coordinators have attended external training. There is a suite of infection control policies and guidelines to support practice. The infection control coordinators use the information obtained through surveillance to determine infection control activities and education needs within the facility over and above which is required from the group head office.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	46	0	4	0	0	0
Criteria	0	96	0	5	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)
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) brochures are accessible to residents and their families. Policy relating to the Code is implemented and care staff interviewed (two caregivers, four registered nurses (RNs), one activities coordinator) could describe how the Code is incorporated into their everyday delivery of care. Staff receive training about the Code during their induction to the service, which continues annually through the staff education and training programme.</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 give informed consent.</p>	FA	<p>There are established informed consent policies/procedures and advanced directives. General consents were obtained on admission as sighted in all six residents' files sampled. Advanced directives (if known) were on the residents' files. Resuscitation plans were in five files and were signed appropriately. The file of the palliative resident had end of life guidelines. Copies of enduring power of attorney (EPOA) were present and activated as required.</p> <p>An informed consent policy is implemented. Systems are in place to ensure residents and where appropriate their family/whānau, are provided with appropriate information to make informed choices and informed decisions. The care staff interviewed demonstrated a good</p>

		<p>understanding in relation to informed consent and informed consent processes.</p> <p>Family and residents interviewed confirmed they have been made aware of and fully understand informed consent processes and that appropriate information had been provided.</p> <p>All resident files sampled had signed admission agreements on file.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Information on advocacy services through the Health and Disability Commissioner's (HDC) office is included in the resident information pack that is provided to new residents and their family on admission. HDC advocacy brochures are also available at reception. Interviews with residents and family confirmed their understanding of the availability of advocacy services. The complaints process is linked to advocacy services.</p> <p>Staff receive regular education and training on the role of advocacy services, which begins during their induction to the service.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>The service has an open visiting policy. Residents may have visitors of their choice at any time. The service encourages residents to maintain their relationships with their friends and community groups. Assistance is provided by the care staff to ensure that the residents participate in as much as they can safely and desire to do.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms for lodging informal complaints (feedback) and formal complaints are readily available. A suggestions box is at reception.</p> <p>Information about the complaints process is provided on admission. Interviews with residents and family members confirmed their understanding of the complaints process. Staff interviewed were also able to describe the process around reporting complaints.</p> <p>An electronic complaints register is maintained. Since the facility opened, three complaints have been received and were reviewed. Evidence was sighted to confirm that each complaint had been managed in a timely manner including acknowledgement, and a comprehensive investigation. Two of the three complaints were resolved. The third complaint, around providing adequate shelving in one resident's room, was still open. The resident was being kept informed.</p>

		Complaints received are communicated to staff, evidenced in the staff meeting minutes.
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Details relating to the Code and the Health and Disability Advocacy Service are included in the resident information folder provided to new residents and their families. An RN discusses aspects of the Code with residents and their family on admission. Discussions relating to the Code are also held during the monthly resident/family meetings. All ten residents (seven rest home level, which included one resident in the service apartments and three hospital level residents) and three families (one rest home level and two hospital level) interviewed reported that the residents' rights were being upheld by the service.</p>
<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>	PA Low	<p>Residents' personal belongings are used to decorate their rooms. All rooms are single occupancy in the care facility, with a selection of rooms with full ensuites. Privacy signage was evident on communal toilet and shower doors; however, signage to indicate whether the toilet/shower was occupied was missing.</p> <p>The caregivers interviewed reported that they knock on bedroom doors prior to entering rooms, ensure doors are closed when cares are being given and do not hold personal discussions in public areas. They reported that they promote the residents' independence by encouraging them to be as active as possible. All of the residents and families interviewed confirmed that residents' privacy is respected.</p> <p>Guidelines on abuse and neglect are documented in policy. Staff receive annual education and training on abuse and neglect, which begins during their induction to the service.</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 Māori are valued and fostered within the service. The care staff interviewed reported that they value and encourage active participation and input from the family/whānau in the day-to-day care of the resident. No residents identified as Māori.</p> <p>Māori consultation is available through links with Māori organisations within the community. Several care staff identify as Māori. Staff receive education on cultural awareness during their induction to the service and continues annually.</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 respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The service identifies the residents' personal needs and desires from the time of admission. This is achieved in collaboration with the resident, family and/or their representative. The staff demonstrated through interviews and observations that they are committed to ensuring each resident remains a person, even in a state of decline. Beliefs and values are discussed and incorporated into the care plan, evidenced in all six care plans reviewed (four rest home including one respite resident and one resident residing in a serviced apartment; and two hospital including one palliative). 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>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>During induction to the service, the professional boundaries policy is discussed and signed by each new employee as evidenced in all six staff files reviewed. Professional boundaries are also defined in job descriptions. Interviews with all care staff confirmed 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.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>Evidence-based practice is evident, promoting and encouraging good practice. A registered nurse is available 24 hours a day, seven days a week. A general practitioner (GP) from the local medical centre visits the facility weekly, at minimum. A general practitioner (GP) reviews residents every three months at a minimum.</p> <p>Staff education and training is provided. Over 90% of staff regularly attend training. In addition to in-service training, staff complete a range of competency assessments. The caregivers interviewed reported that education and training sessions are very informative and helpful.</p> <p>Resident/family meetings are held monthly, led by the activities coordinator. Residents and families interviewed reported that they are very satisfied with the services received. A satisfaction survey of the care facility is planned, (note: the facility has been open for less than one year).</p> <p>A 'best practice sheet' is embedded into practice, which documents when quality activities are completed each month.</p> <p>The service receives support from the district health board (DHB) which includes (but is not limited to) specialist visits (eg, mental health services). Physiotherapy services are available</p>

		<p>as needed. 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 services provided to the resident on entry to the service, and any items they have to pay for that is not covered by the agreement. Regular contact is maintained with families including when an incident or care/health issues arises. This was evidenced in all 10 accident/incident forms that were randomly selected for review. Interviews with families confirmed that they are kept informed.</p> <p>A formal agreement is in place with an external provider for interpreter and translation services. The information pack is available in large print and can be read to residents. 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 by the Sea provides rest home and hospital level care for up to 30 residents. An additional 10 serviced apartments are certified for rest home level of care. On the day of the audit, there were 27 residents in the care facility (21 at rest home level and 6 at hospital level) and one rest home level resident in the serviced apartments. All residents' rooms in the care facility are certified for dual-purpose.</p> <p>Twenty-three residents were on the aged-related care contract (19 rest home and 4 hospital). Two residents (hospital-medical) were on a palliative care contract, and three residents (rest home level) were respite level.</p> <p>Summerset by the Sea includes a retirement village. An acting village manager is responsible for the retirement village until the village manager vacancy is filled. The acting village manager previously was the activities coordinator for the village.</p> <p>The nurse manager/RN is responsible for operations in the care facility and serviced apartments. She has seven years of experience as a nurse manager in the aged care sector and was employed at another Summerset facility before beginning her employment at Summerset by the Sea in August 2015. The nurse manager was on leave during the audit and was unable to be interviewed. The RN staff and the Summerset national education manager assisted in her absence.</p>

		<p>The organisation is guided by a philosophy, vision and values. A 2016 operations business plan, specific to Summerset by the Sea, lists six measureable goals and objectives. Business goals are regularly reviewed.</p> <p>The nurse manager has attended a minimum of eight hours professional development activities related to managing an aged care facility.</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 office manager is responsible for the administrative functions of the facility during any absence of the village manager and/or nurse manager, and the RNs ensure that the nurse manager's role is covered in her absence.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	PA Low	<p>The quality and risk management programme is established through the head office. The organisation's clinical quality manager (a position that was vacant at the time of the audit), oversees quality. 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, then sign that they have read and understand the changes. The village manager and nurse manager are held accountable for their implementation.</p> <p>The monthly collating of quality and risk data includes (but is not limited to) residents' falls, infection rates, skin tears and pressure injuries. To identify trends, data is collated and benchmarked against other Summerset facilities. A resident satisfaction survey is planned for later in the year. An annual internal audit schedule is being implemented with audits completed as per the schedule. Meeting minutes did not evidence that quality data and results were being communicated to staff.</p> <p>Corrective actions have not routinely been developed or fully implement where opportunities for improvements were identified.</p> <p>Falls prevention strategies are being implemented. This includes the implementation of interventions on a case-by-case basis to minimise future falls. Sensor mats and physiotherapy services are utilised.</p> <p>The health and safety programme meets current legislative requirements and overseen by a health and safety officer, and is supported by a health and safety team. A comprehensive contractor induction programme is in place. Hazard identification forms and a hazard register are being implemented. Reporting is electronic, and includes senior management input for</p>

		high-risk events. Links are in place to ensure the board is kept informed of any high-risk events.
<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>	FA	<p>The service collects a comprehensive set of data relating to adverse, unplanned and untoward events, which is linked to the quality and risk management system (link 1.2.3.6 and 1.2.3.8). This includes, but is not limited to, the collection of adverse event data. Immediate actions taken are documented on the 10 accident/incident forms reviewed. The forms are reviewed and investigated by an RN (all clinical events) or by the village manager. If risks are identified, these are processed as hazards and reported to the health and safety officer for evaluation at health and safety meetings.</p> <p>Discussions with the acting village manager and one RN confirmed their awareness of statutory requirements in relation to essential notification. This has not been required. This information is also provided by the Summerset organisation as reference material.</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>Job descriptions are in place for all relevant positions that describe staff roles, responsibilities and accountabilities. The practising certificates of nurses were current. The service maintains copies of other visiting practitioners practising certificate. Six staff files were reviewed (three caregivers, one enrolled nurse and two RNs). Evidence of signed employment contracts, job descriptions, orientation, and staff training were sighted.</p> <p>Annual performance appraisals for staff are regularly conducted. Newly appointed staff complete an orientation that is specific to their job duties. Interviews with all three caregivers confirmed that the orientation programme included a period of supervision over three days.</p> <p>The service has a training policy and schedule for in-service education. The in-service schedule is implemented and attendance is recorded. A system for determining staff competency is implemented. The competencies for RNs includes (but is not limited to) medication, syringe driver and insulin administration.</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. Registered nurses are rostered on 24 hours a day, seven days a week. In addition to an RN, there are a minimum of three caregivers rostered 24/7. Caregiver responsibilities include laundry and cleaning duties. Separate cleaning staff are available from 8am – 12pm seven days a week.</p>

		Staff reported that staffing levels and the skill mix was safe although the RNs commented that they are extremely busy. Interviews with residents and families confirmed that they felt there was sufficient staffing. The roster can be changed in response to resident acuity.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	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 each resident's individual record. An initial support plan is also 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 areas. Residents' files demonstrate service integration. Entries are legible, dated, timed and signed by the relevant caregiver or nurse, including designation.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	Residents' entry into the service is facilitated in a competent, equitable, timely and respectful manner. Pre-admission information packs are provided for families and residents prior to admission. The service has a comprehensive information folder for residents/families/whānau at entry. Admission agreements reviewed align with all contractual requirements. Exclusions from the service are included in the admission agreement.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Planned exits, discharges or transfers are coordinated in collaboration with the resident and family to ensure continuity of care. There are documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The DHB 'yellow envelope' is used for admissions and the InterRAI transfer form is used by the service along with a Medimap printout of medications for transfers/discharges.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	There are policies and procedures in place for safe medicine management that meets legislative requirements. Clinical staff who administer medications (RNs and three caregivers) have been assessed for competency. Education around safe medication administration has been provided. Staff were observed to be safely administering medications at two rounds. Standing orders are not used. One resident is self-medicating with competency reviewed by the GP and RN three monthly. Medications are stored, and

		<p>managed in line with current best practice and guidelines.</p> <p>An electronic system for charting and the recording of medications administered is in use. All 12 medication charts sampled met legislative prescribing requirements. The GPs had reviewed the medication charts three monthly. All medications had been administered as prescribed.</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>	PA Low	<p>A qualified cook and six staff prepare and cook all meals on site. There is an eight weekly menu for spring/summer and another for autumn/winter which has been reviewed by a dietitian (16 Mar 2016). Food, once cooked, is transferred in a 'hot box' to the bain-marie in the servery for plating. Dietary needs are known with individual likes and dislikes accommodated. Dietary requirements, cultural and religious food preferences are met. Additional or modified foods are also provided by the service.</p> <p>Staff were observed assisting residents with their meals and drinks in the dining room and in individual residents' rooms. Resident meetings (the cook receives the minutes of the meetings monthly), a weekly audit of a meal and surveys, along with direct input from residents (there is a comment book in the dining room), provide resident feedback on the meals and food service. Residents and family members interviewed were satisfied with the food and confirmed alternative food choices were offered.</p> <p>Fridge and freezer temperatures are taken and recorded daily in the kitchen, but not in the servery. End cooked food temperatures are recorded on each meal. The chemical supplier checks the dishwasher regularly.</p> <p>All food services staff have completed training in food safety and hygiene and chemical safety.</p> <p>Nutrition and safe food management policies define the requirements for all aspects of food safety. A kitchen cleaning-schedule is in place and implemented. Containers of food are labelled and dated. It was observed that a care staff member responsible for breakfast preparation did not wear a hair cover.</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</p>	FA	<p>There is an admission information policy. The reasons for declining entry would be if the service were unable to provide the care required or there were no beds available. Management communicate directly with the referring agencies and family/whānau as appropriate if entry was declined.</p>

consumer and/or their family/whānau is managed by the organisation, where appropriate.		
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>The RN completes an initial assessment on admission, which includes risk assessment tools. An InterRAI assessment is undertaken within 21 days of admission and six monthly, or earlier due to health changes. Resident needs and supports are identified through the ongoing assessment process in consultation with significant others. InterRAI assessments, assessment notes and summaries were in place for four of the six resident files sampled. The long-term care plans in place reflected the outcome of the assessments.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Resident care plans sampled were resident focused and individualised. All identified support needs as assessed were included in the care plans for all residents' files sampled. Care plans evidenced resident (as appropriate) and family/whānau involvement in the care plan process. Relatives interviewed confirmed they were involved in the care planning process. Resident files demonstrate service integration.</p> <p>There was evidence of allied health care professionals involved in the care of the residents including physiotherapist, podiatrist, dietitian and input from the DHB's mental health and older person's assessment unit. The district nursing service was available for wound advice.</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>	FA	<p>When a resident's condition alters, a registered nurse initiates a review and if required, GP and relevant allied health input is sought. There is evidence that family members are notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. Discussions with families and notifications are documented in the resident file.</p> <p>Adequate dressing supplies were sighted in the treatment room. Wound management policies and procedures are in place for nine wounds. Wound assessments, plans and evaluations were in place for all current wounds and skin tears.</p> <p>Continence products are available and residents' files include a continence assessment and continence products to use.</p> <p>Residents are weighed monthly or more frequently if weight is of concern. Nutritional requirements and assessments are completed on admission identifying resident nutritional status and preferences. Monitoring occurs for weight, vital signs, blood glucose, pain and</p>

		<p>challenging behaviour (link to finding 1.2.3.8).</p> <p>Short-term care plans document appropriate interventions to manage short-term changes in health.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The service has an activities coordinator who, along with her assistant, is currently working towards attaining a diversional therapy qualification. Between them, they work 72 hours per fortnight providing individual and group activities for rest home and hospital residents thirteen days per fortnight. The monthly programme is an inclusive programme for both rest home and hospital residents.</p> <p>Activities provided are appropriate to the needs, age and culture of the residents. The activities are physically and mentally stimulating. One-on-one activities occur for residents who are unable, or choose not to be involved in the group activities. The weekly activities programme is posted throughout the facility and includes activities, exercises and social events. Kindergarten children come once a month and entertainers two to three times a month. These include line dancers and 'dancing divas'. Volunteers assist with reading to residents and walking residents.</p> <p>An activity assessment is completed on admission in consultation with the resident/family (as appropriate). Weekly progress notes are maintained for each resident detailing what they wish to participate in, enjoy, or are not interested in.</p> <p>Families are invited to the resident meetings. The service also receives feedback and suggestions for the programme through surveys and one-on-one feedback from residents (as appropriate) and families.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The RN evaluated all initial care plans (sampled) within three weeks of admission. Long-term care plans have been reviewed at least six monthly or earlier for any health changes. The GP reviews the residents at least three monthly or earlier if required. Ongoing nursing evaluations are documented and are evident in changes made to care plans.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p>	FA	<p>Referral to other health and disability services is evident in the residents' files sampled. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files.</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>		<p>There are documented policies and procedures in relation to exit, transfer or transition of residents. The residents and the families are kept informed of the referrals made by the service.</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 during service delivery.</p>	<p>FA</p>	<p>Documented processes for the management of waste and hazardous substances are in place. Material safety datasheets are readily accessible for staff. Chemical bottles sighted have correct manufacturer labels. Chemicals are stored in locked areas and safety datasheets are available. Personal protective clothing was available in the laundry for staff to wear when carrying out their duties.</p>
<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>	<p>FA</p>	<p>The building has a current building warrant of fitness posted in a visible location (expiry 15 January 2017).</p> <p>A maintenance person is employed and ensures daily maintenance requests are addressed and a planned maintenance schedule is maintained. Essential contractors are available 24 hours. Equipment and medical equipment are currently under warranty. Equipment that has required checking and calibration has been actioned. Hot water temperatures in resident areas are monitored.</p> <p>The facility has wide corridors with sufficient space for residents to safely mobilise using mobility aids. There is safe access to outdoor areas. Seating and shade is provided.</p> <p>The care staff and RNs interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the residents' care plans.</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>	<p>FA</p>	<p>Toilet and shower facilities are of an appropriate design to meet the needs of the residents. There are rooms with ensuites and others that have communal use of nearby bathrooms/toilets. Communal toilet facilities are lacking appropriate privacy measures (link to finding 1.1.3.1).</p>

<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>All rooms are single rooms. There is adequate room in the resident bedrooms to safely manoeuvre mobility aids and transferring equipment, such as hoists. Residents and families are encouraged to personalise their rooms. This was evidenced during the audit.</p>
<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>	<p>FA</p>	<p>Communal areas within the facility include a large lounge and dining area in which seating and space is arranged to allow both individual and group activities to occur. There is an additional smaller lounge. The facility is light and odour free with outlooks to the grounds and wider views. There is a designated resident outside smoking area. All furniture is safe and suitable for the residents.</p>
<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>	<p>FA</p>	<p>There are adequate policies and procedures to provide guidance regarding the safe and efficient use of laundry services. Protective equipment was evident in the laundry. Care staff carries out the laundry. Residents and family interviewed reported satisfaction with the cleaning and laundry service. Internal audits monitor the effectiveness of the cleaning and laundry processes.</p> <p>The service conducts regular reviews and internal audits of cleaning and laundry services to ensure these are safe and effective (link to findings 1.2.3.6 and 1.2.3.8). Current safety material datasheets for each product are located with the chemicals, along with guidance for each chemicals use. The chemicals are stored appropriately in locked areas at all times.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Emergency and disaster policies and procedures, and a civil defence plan for the service, are documented. The fire evacuation plan was approved on 15 September 2015. Fire drills have been conducted six monthly. The orientation programme and annual education and training programme include fire and security training. Staff interviewed confirmed 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. In the event of a civil defence emergency, there are adequate supplies readily available on each floor of the facility including food, water and blankets. Two gas barbeques are available.</p> <p>A call bell system is in place. Residents were observed in their rooms with their call bell alarms in close proximity. The nurses also carry walkie-talkies for aid with communication between the ground and first levels. (Note: the serviced apartments are on the ground level)</p>

		<p>and the care facility is located on the first level).</p> <p>There is a minimum of one staff 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>Residents were provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p> <p>There are sufficient doors and external opening windows for ventilation. All bedrooms have adequate sized external opening windows that are designed and installed to promote ventilation and to be secured as needed.</p> <p>The residents and family interviewed confirmed the internal temperatures and ventilation are comfortable.</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 (IC) coordinator (rostered RN with previous experience as an infection control coordinator) and an enrolled nurse oversee infection control for the facility and are responsible for the collation of infection events. Infection events are collated monthly and entered on 'SWAY', and graphs of data are presented at monthly meetings and placed for viewing in the staff room. The Summerset IC education programme is followed (hand hygiene education was provided in February and standard precaution education provided in June) along with additional education on infection control identified as relevant to the facility/residents/staff.</p> <p>Monthly reviews of the IC plan are occurring and the annual infection-control programme review is due November 2016. Follow up action is taken if an area for improvement is identified and then re-audited to determine if improvement has occurred.</p> <p>Hand sanitisers are appropriately placed throughout the facility. Residents are offered the influenza vaccine.</p> <p>Infection controls are appropriate to the size and scope of the service.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and</p>	FA	<p>The infection control coordinator has a defined position description and is allocated four hours per month to focus on the role with assistance from the EN. Both IC personnel have attended education covering their role and the Summerset infection control programme. The infection control coordinator has access to GPs, local laboratory, fellow Summerset IC coordinators</p>

information resources to implement the infection control programme and meet the needs of the organisation.		and head office for advice.
<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	<p>The infection control policies include a comprehensive range of standards and guidelines including defining roles and responsibilities for the prevention of infection, training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. The policies are provided by head office and are reviewed regularly. The IC coordinator is able to establish procedures relevant to the site.</p>
<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	<p>The infection control coordinator and EN are responsible for coordinating/providing education and training to staff. Training on infection control is included in orientation and as part of the annual training schedule. Hand hygiene competencies are completed on orientation and are ongoing.</p> <p>Resident education is expected to occur as part of providing daily cares as appropriate.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator and EN collate information obtained through surveillance to determine infection control activities and education needs in the facility. Individual infection reports and short-term care plans are completed for all infections. Infection control data and relevant information is displayed for staff. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is discussed at both the registered nurse and general staff meetings. Annual infection control reports are provided. Trends are identified and preventative measures put in place. Internal audits for infection control are included in the annual audit schedule.</p> <p>There have been no outbreaks.</p>
Standard 2.1.1: Restraint minimisation	FA	There are policies around restraints and enablers. One hospital resident using bedrails as an enabler met all requirements of the restraint standard for enabler use. Three hospital

<p>Services demonstrate that the use of restraint is actively minimised.</p>		<p>residents had restraint in use in the form of bed rails and/or lap belts. Staff receive mandatory training around restraint minimisation that includes annual competency assessments. Annual restraint competency questionnaires ask staff to differentiate a restraint from an enabler. Enablers are voluntary.</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 nurse manager is the designated restraint coordinator. She was unavailable during the audit. An RN filling this role in her absence was interviewed.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>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/enabler assessment tool meets the requirements of the standard.</p> <p>Two hospital level residents' files where restraint was being used (bed rails and lap belt), were selected for review. Each file included a restraint assessment and consent form that was signed by the resident's family. Restraint use was linked to the resident's care plan and was regularly reviewed. Their care plans provided factual information in assessing the risks of safety and the need for restraint. Consultation with the resident and/or family/whānau was also identified in each resident's file.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>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 assessments reviewed identified that restraint is being used only as a last resort. The restraint assessment process includes determining the frequency of monitoring residents while on restraint. All residents using restraints and enablers are monitored every two hours. Monitoring forms are completed when the restraint is put on and when it is taken off.</p>

<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>PA Low</p>	<p>The restraint coordinator reviews restraint use monthly. Reviews lack detail as required under criterion 2.2.4.1. Restraint use is a regular agenda item in the monthly RN meetings.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The national quality manager and the national education manager evaluate the restraint programme, including reviewing policies and procedures and staff education, annually.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.3.1</p> <p>The service respects the physical, visual, auditory, and personal privacy of the consumer and their belongings at all times.</p>	PA Low	The facility opened in September 2015, and provides residents with their own private room. A selection of the residents' rooms includes ensuites. Two communal toilets and showers did not have signage on the doors to indicate their function. This was corrected during the audit. These same areas did not have a means for residents to indicate that the toilet/shower was engaged.	Two communal toilets/showers were lacking privacy measures to indicate when the facilities were in use. One of these rooms has two entrances.	<p>Ensure that the communal toilets/showers restrict access when in use. Special consideration will be required for the toilet/shower with two entrances.</p> <p>90 days</p>

<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	<p>PA Low</p>	<p>Quality improvement data is being collected, analysed and evaluated. Data is benchmarked against other Summerset facilities with targets established. The internal audit programme is being implemented. Gaps in meeting minutes were noted around the reporting of quality data and trends in the data. The meeting agenda reflected internal audits that were completed, however, the internal audit results were missing. Staff have not been kept informed of quality data results that are benchmarked against other Summerset facilities (eg, falls, skin tears, pressure injuries, medication errors).</p>	<p>Quality and risk data results have not been fully communicated to staff</p>	<p>Ensure staff are kept informed of quality data outcomes, trends and corrective actions.</p> <p>90 days</p>
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	<p>PA Low</p>	<p>A robust corrective action process is established for the Summerset organisation but is not fully implemented at this facility.</p> <p>Corrective action plans established where internal audits reflected shortfalls were not consistently implemented and evaluated. Corrective actions where quality data exceeded the Summerset benchmarking thresholds were not established.</p>	<p>i) Evidence to support the implementation and the evaluation of corrective action plans were missing in fifteen out of 20 internal audits reviewed. ii) Corrective action plans were not established where data exceeded</p>	<p>i) Ensure corrective action plans are implemented and evaluated. ii) Ensure corrective action plans are established where data exceeds acceptable targets.</p>

			acceptable targets (eg, falls [May 2016], weight loss [Feb, Mar 2016]).	90 days
<p>Criterion 1.3.13.5</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p>	PA Low	<p>The service has a large workable kitchen. The kitchen and equipment are well maintained. Food safety information and a kitchen manual are available in the kitchen. Fridge and freezer temperatures are monitored in the kitchen but not in the servery. Kitchen staff were observed wearing head covering. A care staff member was not wearing a protective hair cover while preparing breakfast. Care staff who assist with breakfast meal preparation have had food service training.</p>	<p>i) There is no evidence that the temperature of the fridge containing food, in the servery, was being taken or recorded. ii) It was observed that a staff member preparing breakfast did not wear a protective hair cover.</p>	<p>Ensure that all aspects of food storage and preparation comply with current legislation and guidelines.</p> <p>60 days</p>
<p>Criterion 2.2.4.1</p> <p>Each episode of restraint is evaluated in collaboration with the consumer and shall consider:</p> <p>(a) Future options to avoid the use of restraint;</p> <p>(b) Whether the consumer's service delivery plan (or crisis plan) was followed;</p> <p>(c) Any review or modification required to the consumer's service delivery plan (or crisis plan);</p> <p>(d) Whether the desired outcome was achieved;</p> <p>(e) Whether the restraint was the least restrictive option to achieve the desired outcome;</p>	PA Low	<p>The evaluation process for restraint use was evidenced with the restraint coordinator (nurse manager) documenting 'reviewed' next to the residents name each month, followed by the nurse manager's signature. Restraint review entries did not evidence that the requirements as described under criterion 2.2.4.1 were being met. Reviews were</p>	<p>Restraint evaluations lack sufficient detail and not dated by the restraint coordinator.</p>	<p>Ensure the restraint evaluations meet requirements listed under 2.2.4.1 (a) – (k), and are dated.</p>

<p>(f) The duration of the restraint episode and whether this was for the least amount of time required;</p> <p>(g) The impact the restraint had on the consumer;</p> <p>(h) Whether appropriate advocacy/support was provided or facilitated;</p> <p>(i) Whether the observations and monitoring were adequate and maintained the safety of the consumer;</p> <p>(j) Whether the service's policies and procedures were followed;</p> <p>(k) Any suggested changes or additions required to the restraint education for service providers.</p>		not dated.		90 days
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.