

# Summerset Care Limited - Summerset at the Course

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## 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:

<b>Legal entity:</b>	Summerset Care Limited
<b>Premises audited:</b>	Summerset - Summerset at the Course
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 19 February 2015      End date: 20 February 2015
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	48

# Executive summary of the audit

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## Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

### Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

## General overview of the audit

Summerset at the Course provides rest home and hospital level care. On the day of audit there were 21 rest home residents (including nine in serviced apartments and two respite care) and 27 hospital residents. The village manager is supported by a nurse manager (who was not available on the day of audit). Summerset's regional manager, clinical educator and clinical and quality manager are available to support the team.

This certification audit was conducted against the Health and Disability Standards and the contract with the District Health Board. This audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management and staff

Improvements are required around job descriptions and documentation of interventions. There is one area of continuous improvement around infection control surveillance.

## 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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Summerset at the Course provides care in a way that focuses on the individual residents' quality of life. There is a Maori Health Plan and implemented policy supporting practice. A cultural assessment is undertaken on admission and during the review process. Policies are being implemented to support individual rights, advocacy and informed consent. Information about the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is readily available to residents and families. Informed consent was sought and advanced directives were appropriately recorded. Residents and family interviewed verified on-going involvement with the community. Complaint processes were being implemented.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Summerset at the Course implements the Summerset framework for quality and risk management. Key components of the quality management system linked to a number of meetings including staff meetings. An annual resident/relative satisfaction survey was completed and there are regular resident/relative meetings. Quality and risk performance has been reported across the various facility meetings and to the organisation's management team. There is human resources policies including recruitment, selection, orientation and staff training and development. The service has an induction programme in place that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care and support and external training is supported. The organisational staffing policy aligns with contractual requirements and included skill mixes.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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The service has assessment processes and residents needs are 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 are available and implemented. Resident centred care plans were individualised.

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.

There is robust medication system that meets legislative requirements. Staff responsible for the administration of medications complete annual medication competencies and education. The general practitioner reviews the medication charts three monthly.

The food service is contracted to an external contract company. Resident's individual dietary needs are identified and accommodated. Staff have attended food safety and hygiene training. Additional snacks are available after hours.

## Safe and appropriate environment

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

Standards applicable to this service fully attained.

There 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 ensembles or shared bathrooms.

The building has a current warrant of fitness. There is a preventative and planned maintenance schedule in place. Chemicals were stored safely throughout the facility. There is sufficient space to allow the movement of residents around the facility using mobility aids or lazy boy chairs. The hallways and communal areas are spacious and accessible. The outdoor areas are safe and easily accessible. Housekeeping staff maintain a clean and tidy environment. All laundry and linen is completed on-site.

## 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.

There are documented policies and procedures around restraint use and use of enablers. There are four residents using restraint and five with enablers. Staff training around the use of restraint and enablers has been provided at orientation and on-going.

There is a restraint co-ordinator (registered nurse) and restraint approval group that meet three monthly. The use of restraint and enablers is reported to the monthly quality meeting.

## 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 is appropriate for the size and complexity of the service. The infection control officer (RN) is responsible for coordinating/providing education and training for staff. The infection control officer has attended external training. The infection control manual outlines the scope of the programme and includes a comprehensive range of policies and guidelines. The infection control officer uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Somerset facilities. There is a continuous improvement awarded around surveillance of infections and the initiative to reduce urinary tract infections.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	1	48	0	1	0	0	0
<b>Criteria</b>	1	99	0	1	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Summerset policies and procedures are being implemented that align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code). Families and residents are provided with information on admission which include the Code. Staff receive training about resident rights (and the Code) at orientation and as part of the annual in-service calendar. Interview with eight caregivers demonstrated an understanding of the Code. Residents interviewed (three rest home and two hospital) and relatives (three rest home and two hospital) confirm staff respect privacy, and support residents in making choice where able.</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>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 and registered nurses 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</p>

		<p>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>
<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>Residents are provided with a copy of the Code on entry to the service. Residents interviewed confirmed they are aware of their right to access independent advocacy services. Discussions with relatives confirmed the service provided opportunities for the family/enduring power of attorney (EPOA) to be involved in decisions. The resident files include information on residents' family/whanau and chosen social networks.</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>Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. Activities programmes included opportunities to attend events outside of the facility including activities of daily living, for example, shopping. Residents are assisted to meet responsibilities and obligations as citizens, for example, voting and completion of the census. Interview with staff, residents and relatives informed residents are supported and encouraged to remain involved in the community and external groups. Relative and friends are encouraged to be involved with the service and care.</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 organisational complaints policy states that the village manager has overall responsible for ensuring all complaints (verbal or written) are fully documented and investigated. A feedback form has been completed for each complaint recorded on the complaint register. There is a complaints register that includes relevant information regarding the complaint. Documentation includes follow up letters and resolution. The number of complaints received each month are reported monthly to</p>

		<p>staff via the various meetings. Discussion with residents and relatives confirmed they have been provided with information on the complaints process. Feedback forms are available for residents/relatives in various places around the facility. A complaints procedure is provided to residents within the information pack at entry.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>There is a welcome pack that includes information about the Code. There is also the opportunity to discuss aspects of the Code during the admission process. Residents and relatives informed information has been provided around the Code. Large print posters of the Code and advocacy information were displayed through the facility. The village manager described discussing the information pack with residents/relatives on admission. The families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.</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>	FA	<p>A tour of Summerset at the Course confirmed there are areas that support personal privacy for residents. During the audit, staff were observed to be respectful of residents' privacy by knocking on doors prior to entering resident rooms. Staff could describe definitions around abuse and neglect that align with the Summerset policy. An annual resident satisfaction survey has been completed and the results showed the overall resident experience is reported as being good or very good (95%).</p> <p>The service has a philosophy that promotes quality of life and involves residents in decisions about their care. Resident preferences are identified during the admission and care planning process with family involvement (seven files reviewed). Interviews with residents confirmed their values and beliefs are considered. There were instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement.</p> <p>Interview with caregivers described how choice is incorporated into resident cares.</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>Summerset has a Maori Health Plan that includes a description of how they achieve the requirements set out in the contract. There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. Family/whanau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with disability and other community representative groups as requested by the resident/family. Cultural needs are addressed in the care plan. At the time of audit the staff reported there were no residents that identify as Maori.</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>An initial care planning meeting is carried out where the resident and/or whanau as appropriate/able are invited to be involved. Individual beliefs or values are further discussed and incorporated into the care plan. Six monthly multi-disciplinary team meetings occur to assess if needs are being met. Family are invited to attend. Discussion with relatives inform values and beliefs are considered. Residents interviewed confirm that staff take into account their culture and values.</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>Staff job descriptions include responsibilities and staff sign a copy on employment. The full facility meetings occur monthly and include discussions on professional boundaries and concerns as they arise. Management provide guidelines and mentoring for specific situations. Interviews with the village manager and registered nurses confirmed an awareness of professional boundaries. Care assistants could discuss professional boundaries in respect of gifts.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>All Summerset facilities have a master copy of policies which have been developed in line with current accepted best practice and are reviewed regularly. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff. A number of core clinical practices also have education packages for staff which are based on their policies. Best Practice Sheets are completed and discussed at the</p>

		<p>management and quality improvement meetings.</p> <p>Clinical indicator data is collected and reported through to head office for monitoring. Indicators include (but not limited to): falls, medication errors and infections. Feedback on incident trending was provided to staff via the various meetings. Quality Improvement Plans are developed where thresholds exceed expectation.</p> <p>Services are provided at Summerset at the Course that adhere to the health &amp; disability services standards.</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>There is an incident reporting policy to guide staff in their responsibility around open disclosure. Staff are required to record family notification when entering an incident into the system. Incidents reviewed met this requirement. Family members interviewed confirmed they are notified following a change of health status of their family member. There is an interpreter policy and contact details of interpreters are available.</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's vision is to be the first choice provider of retirement village and aged care services in New Zealand ".</p> <p>The Summerset Group Limited Board of Directors have overall financial and governance responsibility and there is a company strategic business plan in place. Summerset at the Course has a site specific business plan and goals that is developed, in consultation with the village manager, nurse manager and regional operations manager (ROM). The plan is separated into sections which include; a) business and financial, b) resident satisfaction, c) clinical care, d) clinical risk, e) property, f) village life, g) leadership, h) customer service, and i) staff The Summerset at the Course quality plan is reviewed regularly throughout the year. There is a full evaluation at the end of the year. The 2014 evaluation was sighted and the 2015 quality plan. The village manager (non-clinical) has been in the current role at Summerset for six years and has attended at least eight hours of leadership professional development relevant to the role. The village manager is supported by a nurse manager. The nurse manager has been employed at the facility as a registered nurse (four years) and a team leader (18 months) prior</p>

		<p>to being appointed as the the nurse manager. Village managers and nurse managers attend annual organisational forums and regional forums over two days. The nurse manager attends clinical education, forums/provider meetings at the local DHB. There is a regional operations manager who is available to support the facility and staff. 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. Advised by the village manager that the regional operations manager is available to be contacted by telephone or email as required. Policies and procedures are developed at an organisational level with input from staff and external specialist expertise where required. An education and training plan is in place.</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>	<p>FA</p>	<p>During a temporary absence, the nurse manager will cover the manager's role. The regional manager and the clinical and quality manager provide oversight and support. The audit confirmed the service has operational management strategies and a quality improvement programme to minimise risk of unwanted events.</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>	<p>FA</p>	<p>Summerset at the Course has an established quality and risk management system. Interviews with staff and review of meeting minutes/quality reports demonstrate a culture of quality improvements. Key components of the quality management system link to the Summerset on the course monthly quality committee through quality reports provided from relevant areas. Monthly (or more often) reporting by the Village Manager to the Operations Manager is part of the process.</p> <p>There are monthly accident/incident benchmarking reports completed by the Clinical Manager that break down the data collected across the organisation these include staff incidents/accidents. The organisation has also linked the complaints process to its quality management system. Communication of this information is disseminated to all staff at</p>

		<p>meeting so that process improvements are facilitated.</p> <p>There is a three monthly IC meeting at Summerset on the course. Infection control is also included as part of benchmarking across the organisation.</p> <p>There is an internal audit plan. Audits include a summary, any issues arising and corrective actions when required. Monthly and annual analysis of results is completed and provided across the organisation. There are monthly accident/incident benchmarking reports completed by the nurse manager that break down the data collected across the rest home and hospital and staff incidents/accidents. Infection control is also included as part of benchmarking across the organisation. Health and safety internal audits are completed. An ACC workplace safety management practices (WSMP) audit is completed annually. Summersets Clinical and Quality Manager analyses data collected via the monthly reports and corrective actions are required based on benchmarking outcomes. Summerset has a data tool "Sway- the Somerset Way" that was launched in 2012 by the organisation. Sway is integrated and accommodates the data entered. The resident and family satisfaction survey is completed annually. Resident satisfaction is also being monitored through resident meetings and verbal feedback.</p> <p>Policies and procedures are developed at organisational level. These documents have been developed in line with current accepted best and/or evidenced based practice and are reviewed regularly by Summersets Clinical and Quality Manager. A number of core clinical practices also have education packages for staff, which are based on their policies. Discussion regarding policy development/review occurs at staff meetings.</p> <p>There is a comprehensive H&amp;S and risk management programme in place. The nurse manager is the health and safety officer. There is a current hazard register.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically</p>	<p>FA</p>	<p>Summerset at the Course collects incident and accident data. Incident forms were reviewed and all had been completed with appropriate clinical follow up. Monthly analysis of incidents by type. Data links to</p>

<p>recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>the organisations benchmarking programme and used for comparative purposes. Action plans were created when the number of incidents exceeded the benchmark – e.g. falls. Action plans were seen to have been actioned and closed out. Senior management were aware of the requirement to notify relevant authorities in relation to essential notifications.</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>	<p>FA</p>	<p>There are organisational policies to guide recruitment practices and documented job descriptions. Appropriate recruitment documentation was seen in the seven staff files reviewed. A register of practising certificates is maintained. Performance appraisals are current in all files reviewed. Interview with the village manager informs of a stable workforce. Interview with care assistants and registered nurses inform management are supportive and responsive.</p> <p>There is an annual training plan that was being implemented. There are two assessors who oversee staff participation in the Careerforce programme which is a requirement for caregivers. 98% are registered or have completed level two. Registered nurses are supported to maintain their professional competency. There is an RN book club, leadership development training via teleconferencing with other Summerset facilities, NetP programme and InterRAI training for all RNs.</p> <p>There is an induction programme being implemented with completion being monitored and reported monthly to head office. Interview with staff informed the induction programme meets the requirements of the service.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The nurse manager works 40 hours per week Monday to Friday and is available on call for any emergency issues or clinical support. At the time of audit the nurse manager was on leave and an experienced relive nurse manager was undertaking the role. The service provides 24 hour RN cover. Two caregivers are allocated to the care apartments on morning and afternoon shifts and they are covered by a senior caregiver in the rest home at night. A staff availability list ensures that staff sickness and vacant shifts are filled. Caregivers interviewed confirmed</p>

		that staff are replaced.
<p><b>Standard 1.2.9: Consumer Information Management Systems</b></p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident 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. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access by being held in the locked nurse's station. Care plans and notes were legible and where necessary signed (and dated) by a registered nurse. Entries are legible, dated and signed by the relevant care assistant or registered nurse including designation. Individual resident files demonstrate service integration. There was an allied health section that contained general practitioner notes and the notes of allied health professionals and specialists involved in the care of the resident.</p>
<p><b>Standard 1.3.1: Entry To Services</b></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>	FA	<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.</p> <p>Residents and relatives interviewed 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>D13.3 the admission agreement reviewed aligns with a) -k) of the ARC contract.</p> <p>D 13.3 k: The admission agreement includes information about when a resident may be required to leave the facility.</p> <p>D14.1: Exclusions from the service are included in the admission agreement.</p> <p>D14.2: 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 medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The service medication management system follows recognised standards and guidelines for safe medicine management practice in accordance with the Medicines Care Guide for Residential Aged Care 2011. RNs are responsible for the administration of medications in the rest home and hospital wings. Medication competencies and education has been completed annually. All medications are checked on delivery with any discrepancies fed back to the supplying pharmacy. Standing orders are current. Currently there are no residents self-medicating. Medication administration was observed to be fully compliant. Medication signing sheets were correctly signed for regular and as required medications.</p> <p>Fourteen resident medication charts sampled (six rest home and eight hospital) were identified with photographs and allergy status. The prescribing of regular and prn medications meets legislative requirements.</p> <p>D16.5.e.i.2; 14 medication charts reviewed 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 include lactose intolerant and pureed meals as assessed for residents by the RN. The cook receives a dietary profile for each resident.</p> <p>The kitchen has large equipment items all purchased within the last year. Other items have been tested and tagged. The fridge, freezer and dishwasher have daily temperatures recorded. End cooked food</p>

		<p>temperatures are recorded twice daily. Cleaning schedules are maintained. Chemicals were stored safely within the kitchen which is locked after hours. Staff were observed wearing correct personal protective clothing.</p> <p>D19.2: Staff working in the kitchen have food handling certificates and 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>	FA	<p>The reason for declining service entry to residents should this occur is communicated to the resident or family/ whanau and they 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 in a timely manner.</p>	FA	<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, cultural needs assessment, pain assessment, challenging behaviour and wound assessments are available for use applicable. Risk assessments were completed on admission and reviewed three monthly in the resident files sampled.</p> <p>Risk assessment tools are used to identify the required needs and interventions required to meet resident goals.</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 centred care plans describe the individual support and interventions required to meet the resident goals. The care plans reflect the outcomes of risk assessment tools (link 1.3.6.1). Care plans demonstrate service integration and include input from allied health practitioners.</p> <p>D16.3k: Short term care plans were in use for changes in health status.</p> <p>D16.3f: There is documented evidence 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. There is documented evidence of communication with families on the family consultation record. When a resident's condition alters, the registered nurses initiate a review and if required, GP or nurse specialist consultation.</p> <p>D18.3 and 4 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 and one pressure area. There is evidence of the wound nurse specialist involvement in wound management.</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>A caregiver who has recently qualified as a diversional therapist (DT) has been in the role for 18 months previously and is providing interim cover. There is a caregiver currently orientating to an activities role and the service is actively recruiting another DT due to the current vacancy. The programme covers a seven day week integrated rest home and hospital activity programme. The programme is planned a month in advance and includes activities coordinated by the activity team, entertainers, themes and events, pet therapy and two outings a week. Couples outings have been initiated. The service has a wheelchair van for outings. The relieving DT has a current first aid certificate. Community links such as library bus, café visits, and gallery visits and walks within the village. Church services are held on-site monthly with weekly bible studies. One on one contact is made with residents who are unable or choose not to participate in group activities. Rest home and hospital advocate meetings provide an opportunity for residents to feedback on the programme</p> <p>D16.5d: The activity assessment and communication assessment is completed in consultation with the family on admission. Activity progress notes are maintained. The activity team are involved in the</p>

		MDT reviews. Activity plans and care plans are reviewed at the same time.
<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. There is evidence of multidisciplinary (MDT) team involvement in the reviews. Short term care plans sighted have been evaluated by the RN. The GP completes three monthly reviews.</p> <p>ARC D16.3c: All initial care plans reviewed 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>D16.4c; The service provided examples of where a residents condition had changed and the resident was reassessed for a higher level of care. D 20.1 Discussions with the RN identified that the service has access to (but not limited to); speech language therapist, community physiotherapist, wound care nurse, needs assessment, social worker, geriatrician, hospice, community dietitian, orthotics and this was evidenced in the files reviewed.</p> <p>Referral to other health and disability services is evident in the sample group of resident files. 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 during service delivery.</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 are readily accessible for staff. Chemical bottles sighted have correct manufacturer labels. Chemicals were stored safely throughout the facility. 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>

<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 that expires on 2 October 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 have been tested and recorded monthly with readings 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. There is an indoor designated smoking area for residents who smoke.</p> <p>ARC D15.3: 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, mobility aids and wheel-on weigh scales.</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>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 personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<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.</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>	FA	<p>Communal areas within the facility include open plan lounge and dining area for the rest home and hospital residents. There are two serviced apartment wings with a dining and lounge area for the rest home residents. There are smaller lounges, conservatories, seating alcoves and a family room within the care centre. The communal areas are easily accessible for 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>	FA	<p>There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. The laundry has a dirty to clean work flow. There are dedicated laundry and housekeeping staff. All linen and personal clothing was laundered onsite. Cleaning trolleys were 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>
<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>	FA	<p>There are emergency and disaster manuals to guide staff in managing emergencies and disasters. Emergencies, first aid and CPR is included in the mandatory in-service programme. There is a first aid trained staff member on every shift. Summerset at the Course has an approved fire evacuation plan and fire dills occur six monthly. Smoke alarms, sprinkler system and exit signs in place. The service has alternative cooking facilities (BBQ) available in the event of a power failure. Emergency lighting is in place for four hours. There are three civil defence kits in the facility and stored water. Call bells are evident in resident's rooms, lounge areas, and toilets/bathrooms. The facility is secured at night. The service utilises security cameras and an intercom system.</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</p>	FA	<p>Visual inspection evidences that the residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>

comfortable temperature.		
<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 is appropriate for the size and complexity of the service. There is an infection control (IC) responsibility policy that included chain of responsibility and an infection control officer job description, the job description was not evident in the file of the infection control officer (#link 1.2.7.3). The infection control programme links into the quality management system. The infection control committee meets bimonthly. The facility meetings also include a discussion of infection control matters. The IC programme is set out annually from head office. The facility had developed links with the GP's, local Laboratory, the infection control and public health departments at the local DHB.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The infection control committee is made up of a cross section of staff from areas of the service including; (but not limited to) the village manager, the clinical manager (who is the IC officer); and maintenance. The facility also had access to an infection control nurse specialist, public health, GP's and expertise within the organisation.</p>
<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>There are comprehensive infection control policies that were 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. There are policies for IC management, b) implementing the IC programme, c) education, d) surveillance, and e) IC policies and procedures related to the prevention of transmission of infection</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 officer is responsible for coordinating/providing education and training to staff. The infection control officer (clinical manager) has appropriate training for the role. The induction package included specific training around hand washing and standard precautions and training was provided both at orientation and as part of</p>

		the annual training schedule. Resident education is expected to occur as part of providing daily cares.
<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>	CI	<p>The infection control policy includes a surveillance policy including a surveillance procedure, process for detection of infection, infections under surveillance, outbreaks and quality and risk management. The infection control committee includes the infection control co-ordinator, caregivers, DT, laundry and kitchen representatives. All infections are documented on short term care plans. An infection control report is provided at the quality meeting. The infection control co-ordinator has access to external training and GP advice as required and has attended an infection control and prevention conference. The infection control data entered on line is reviewed by the Somerset Clinical Quality Manager monthly and any areas for improvement are highlighted and follow up corrective action is discussed with the nurse manager and infection control officer at the relevant facility. The facility is benchmarked against other Somerset facilities of similar size and benchmarking results are fed back to the infection control officer and used to identify areas for improvement. Infection control audits are completed and corrective actions are signed off (sighted). Staff receive infection control education during orientation and as per the education schedule. There has been a focus on reducing urinary tract infections that has successfully reduced numbers.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There are policies around restraint, enablers and the management of challenging behaviours which meet requirements of HDSS 2008. Policy dictates that enablers should be voluntary and the least restrictive option possible. The service currently has five residents using enablers. The resident has made a voluntary choice for enablers. The three resident files sampled reflect the use of enabler, have signed consents and risks identified with the use of the enablers are identified in the care plan. On-going consultation with the resident and family/whanau is evident.</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>Responsibilities and accountabilities for restraint are outlined in the restraint officer job description (link 1.2.7.3). The restraint committee meet three monthly for the approval and review of restraints and enablers. The resident (if appropriate) and relatives receive information on the use of restraints. Restraints are reviewed at a frequency as determined by organisational Restraint Minimisation policy and resident safety. There are four residents with restraint (bedrails/lap belts). Two files reviewed evidenced consent forms completed appropriately.</p> <p>Restraint education is included in care staff orientation. On-going education is provided and staff complete restraint competencies.</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>Summerset Restraint Minimisation policy outlines the organisation approach to managing restraint. This includes the use of a restraint assessment guide by the Restraint Coordinator and GP. The risk assessment includes a) to h) as listed in 2.2.2.1.</p> <p>Two files reviewed documented an in-depth assessment including the consideration of alternatives. Family/whanau input and consent is required prior to the application of any forms of restraint at Summerset.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>Restraint policy states that the need for restraint use is monitored and reviewed as part of the three monthly care plan reviews. Two of four resident restraint files sampled identified three monthly reviews. The service reviews all restraint use as part of the monthly quality meetings. Restraint monitoring and frequency is carried out as directed and includes documentation of the cares delivered to the resident during each episode of restraint. Restraint use is discussed at clinical meetings. Restraint is only used at Summerset at the Course as a last resort after all other alternative techniques to modify behaviour or manage resident safety has been exhausted. This is outlined as policy requirements in the Restraint Minimisation Policy. The restraint register is maintained and updated by the Restraint Coordinator as required.</p>

<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>The use of restraining devices is evaluated by the Restraint Coordinator and registered nurses as part of the care planning review process in conjunction with the resident, their family/whanau and GP. Points a) to k) above are considered as part of this review. On review of five files (two restraint and three enabler) all have been reviewed three monthly as per policy. Restraint use is discussed at the monthly quality 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>Summerset at the Course reviews restraint use as part of its internal audit processes. The results of the restraint audit are discussed at the monthly quality meetings and any corrective actions identified are actioned through this forum.</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 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	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.	(i) The resident centred care plan for one rest home resident does not reflect the outcome of the reviewed falls risk; (ii) There were no recordings taken on admission or the following month for one respite care resident, (iii) Occupational therapist recommendations following a referral have not been implemented for one hospital resident.	<p>(i) Ensure care plans reflect the outcomes of risk assessments; (ii) Ensure recordings are completed for all residents on admission and monthly thereafter; (iii) Ensure allied health recommendations are followed up and implemented.</p> <p>90 days</p>

## Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, 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>Infections under surveillance are eye, UTI, respiratory, wound, multi-resistant organisms, skin and soft tissue, diarrhoeal and other. A monthly data base of infections are summarised and graphed. The infection control officer provides information to staff including trends and correction actions required. Staff interviewed state infection control information is available and discussed at staff meetings.</p>	<p>Summerset have introduced a new infection control surveillance programme to improve the robustness of data collection. This was fully implemented at Summerset at the Course with this new programme using data collection sheets based on best practice from an external infection control specialist. The service has undertaken a number of initiatives as a result of infection surveillance data to reduce infection numbers. 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</p>

			<p>infection rates.</p> <p>In response to urinary tract infections a prevention programme was instigated where fluids were offered more frequently. Caregivers interviewed were enthusiastic about the initiative and the training the infection control coordinator was providing them. They reported that they initiate resident infection reports. UTI's had reduced in 2014 with six months in the year having no UTI's and three months having only one</p>
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End of the report.