# Summerset Care Limited - Summerset on the Coast

## Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Summerset Care Limited

**Premises audited:** Summerset on the Coast

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 18 February 2015 End date: 18 February 2015

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 39

# 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 |
|  | 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 on the Coast provides rest home and hospital level care for up to 42 residents and on the day of the audit there were 39 residents. The service is managed by a village manager and a nurse manager. The residents and relatives interviewed spoke positively about the care and support provided.

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

The service has addressed the shortfall from the previous certification audit around medication management. The continuous improvement identified around infection control remains. Two improvements are required around performance appraisals and interventions to reflect the residents’ current needs.

## Consumer rights

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| 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. |

Residents and families are kept informed. Residents and their family/whanau are provided with information on the complaints process on admission. Complaints are being managed in a timely manner. Staff are aware of the complaints process and to whom they should direct complaints.

## Organisational management

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| 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. |

Services are planned, coordinated, and are appropriate to the needs of the residents. A village manager and nurse manager/registered nurse are responsible for the day-to-day operations of the facility. Quality and risk management processes are maintained, reflecting the principals of continuous quality improvement. Quality goals are documented for the service. Corrective action plans are implemented where opportunities for improvement are identified. A risk management programme is in place, which includes a risk management plan, incident and accident reporting, and health and safety processes. Adverse, unplanned and untoward events are documented by staff.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice, meeting legislative requirements. An orientation programme is in place for new staff. On-going education and training for staff is in place.

Registered nursing cover is provided 24 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

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| 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. |

Assessments, resident centred care plans and evaluations were completed by the registered nurses within the required timeframes. Risk assessment tools and monitoring forms were available and implemented. Resident centred care plans are individualised.

Recreational therapists develop and provide a seven day week activity programme. Community links are maintained. There is volunteer involvement 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 previous finding around transcribing and medication documentation has been addressed.

The food service is contracted externally. 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

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| 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. |

A current building warrant of fitness is posted in a visible location. One resident room was assessed as suitable for rest home level care.

## Restraint minimisation and safe practice

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| 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. |

Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. The service currently has six residents assessed as requiring the use of restraint and three requiring enablers.

## Infection prevention and control

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| 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 and its content and detail is appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator (enrolled nurse) has defined responsibilities for the monitoring of infections. Surveillance activities include audits of the facility, hand hygiene and surveillance of infection control events and infections. Staff receive on-going training on infection control.

## Summary of attainment

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

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| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 1 | 13 | 0 | 2 | 0 | 0 | 0 |
| **Criteria** | 0 | 36 | 0 | 2 | 0 | 0 | 0 |

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| --- | --- | --- | --- | --- | --- |
| **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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

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| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The service has a complaints policy that describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission. Interviews with five residents (three rest home level and two hospital level) and family members confirmed their understanding of the complaints process. Staff interviewed (three caregivers, one registered nurse (RN), one enrolled nurse (EN), one recreational therapist) were able to describe the process around reporting complaints.  There is an electronic complaints register that includes verbal and written complaints and evidence to confirm that complaints are being managed in a timely manner including acknowledgement, investigation, time lines, and corrective actions when required and resolutions. Complainants are provided with information on how to access advocacy services through the Health and Disability Commissioner if resolution is not to their satisfaction. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | An open disclosure policy describes ways that information is provided to residents and families. The admission pack gives a comprehensive range of information regarding the scope of service provided to the resident and their family on entry to the service and any items they have to pay that is not covered by the agreement. Regular contact is maintained with family including if an incident or care/ health issues arises. Two family members interviewed (one rest home level and one hospital level) stated they were well informed. Eight incident/accident forms were reviewed and all identified that the next of kin were contacted.  There are three monthly residents meetings chaired by a resident advocate where any issues or concerns to residents are able to be discussed. Minutes are maintained and show follow-up actions for resolution of matters raised. Plans are in place to conduct monthly residents meetings with the activities staff.  The service has policies and procedures available for access to DHB interpreter services and residents. The information pack is available in large print and can be read to residents.  Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Summerset on the Coast provides rest home and hospital level care for up to 42 residents. This includes the addition of one room assessed as suitable for rest home level care. The remaining rooms are approved for both rest home or hospital level residents. On the day of the audit there were 39 residents - 12 rest home level and 27 hospital level. There is a retirement village attached as part of the complex with overall management of the site provided by a village manager.  A strategic plan is in place for the organisation. An annual quality plan for the service is linked to the strategic plan and includes annual goals and objectives. Quality is overseen by the organisation’s clinical quality manager.  The village manager has been employed by Summerset for over seven years. He has been the village manager at this facility since March 2013. Prior to working in the aged care industry, he worked in the hospitality industry. The nurse manager is a registered nurse employed to oversee the running of the rest home and hospital. He has been working at this facility since June 2014 and has worked in aged care for over five years.  The village manager and nurse manager have maintained greater than eight hours of professional development activities related to managing an aged care facility. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | A quality and risk management plan is in place. Policies and procedures reflect evidence of regular reviews as per the document control schedule. New and/or revised policies are made available for staff to read and sign that they have read and understand the changes. Village managers and nurse managers are held accountable for their implementation.  The monthly collating of quality and risk data includes (but is not limited to) residents’ falls, infection rates, and pressure areas. Data is collated and benchmarked against other Summerset facilities to identify trends. A resident satisfaction survey is conducted each year. Results for 2014 reflect resident satisfaction with the services received. An annual internal audit schedule was sighted for the service. There was a gap in completing audits from January 2014 – March 2014. This issue has been rectified. Corrective actions are developed where opportunities for improvements are identified and are signed off by the village manager or nurse manager when completed. Staff are kept informed of audit findings and quality initiatives.  A falls reduction plan was sighted for the service. Falls prevention strategies are in place that include the identification of interventions on a case-by-case basis to minimise future falls. Sensor mats and physiotherapy services are utilised.  The health and safety programme is overseen by a health and safety team that meets three-monthly. Two health and safety representatives have completed their stage three health and safety training. Hazard identification forms and a hazard register are in place. Hazards are listed at the entrance to the facility. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. The reporting system is integrated into the quality and risk management programme. Once incidents and accidents are reported the immediate actions taken are documented on incident forms. The incidents forms are then reviewed and investigated by the nurse manager. If risks are identified these are processed as hazards.  Discussions with the village manager and nurse manager have confirmed their awareness of statutory requirements in relation to essential notification. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Low | There are job descriptions available for all relevant positions that describe staff roles, responsibilities and accountabilities. The practising certificates of nurses are current. The service also maintains copies of other visiting practitioners practising certificates including GP, pharmacist and physiotherapist. Five staff files were reviewed (three caregivers and two registered nurses). Evidence of signed employment contracts, job descriptions, orientation, and training was available for sighting. Annual performance appraisals for staff have not been conducted annually. Newly appointed staff complete an orientation that is specific to their job duties. Interviews with three caregivers described the orientation programme that includes a period of supervision.  The service has a training policy and schedule for in-service education. The in service schedule is implemented and attendance is recorded. For those staff members who are unable to attend education, a competency is completed.  There are implemented competencies for registered nurses including (but not limited to); medication, restraint, syringe driver and insulin administration. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. An RN is scheduled 24 hours a day, seven days a week. Staff reported that staffing levels and the skill mix was appropriate and safe. All families interviewed advised that they felt there was sufficient staffing. Advised that the roster is able to be changed in response to resident acuity. |
| 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 | 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 and enrolled nurses are responsible for the administration of medications in the rest home and hospital wings. Medication sheets are correctly signed following the administration of medication. This is an improvement since the previous audit. Annual medication competencies were completed July 2014. All incoming medications are checked against the medication charts. Standing orders are current. There are no residents self-medicating. The medication fridge temperature is recorded daily. Emergency equipment is checked weekly.  Ten resident medication charts sampled (four rest home and six hospital) are identified with photographs and allergy status. The prescribing of regular and prn medications meets legislative requirements. There was no transcribing of medications. This is an improvement since the previous audit. The ten medication charts reviewed identified that the GP had reviewed the medication chart three monthly. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | An external provider is contracted for the provision of meals on-site. 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 gluten free, lactose free, peanut free (allergy based) and pureed meals as assessed for residents by the RN. The cook receives a dietary profile for each resident (link to finding 3.6.1).  The kitchen is well equipped and all equipment has monthly service checks. The fridge, freezer and dishwasher have daily temperatures recorded. End cooked food temperatures are recorded daily. Cleaning schedules are maintained. Chemicals are stored safely within the kitchen which is locked after hours. Staff were observed wearing correct personal protective clothing.  Staff working in the kitchen have food handling certificates and chemical safety training. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Low | Residents interviewed state their needs are being met. Relatives interviewed state their relatives needs are met and they are kept informed of any health changes, GP visits and care plan reviews. There is documented evidence of communication with families on the consultation record When a resident's condition alters, the registered nurses initiate a review and if required, GP or specialist consultation.  Dressing supplies are available and a treatment room is stocked for use. Continence products are available and residents’ files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed.  There were initial wound assessments and on-going assessment and treatment plans in place for three skin tears. There were no pressure areas.  Two hospital files did not have all documented interventions to support resident needs. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The service employ two recreational therapists to cover a seven day week integrated rest home and hospital activity programme. The recreational therapists have commenced diversional therapy training and have current first aid certificates.  The programme is planned a month in advance and includes activities coordinated by the activity team, entertainers, themes and events, and musical therapy. Community links are maintained. Church services are held on-site. Daily contact is made with residents who are unable or choose not to participate in group activities. The service has a wheelchair van for outings. The service has identified a need for increased frequency of outings and this is currently being addressed.  The activity assessment is completed in consultation with the family on admission. Monthly progress notes are written. Therapy plans sighted in resident files were reviewed six monthly. The recreational therapists are involved in the multi-disciplinary team (MDT) reviews. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | There is evidence of resident and family involvement in the review of resident centred care plans. Written evaluations were completed in all files sampled. There is evidence of MDT involvement in the reviews. Short term care plans are evaluated by the RN daily.  All initial care plans are evaluated by the registered nurses within three weeks of admission. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness is posted in a visible location (expiry 9 Feb 2016). |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | CI | Infection monitoring is the responsibility of the infection control coordinator (enrolled nurse). The infection control policy describes routine monthly infection surveillance and reporting. Monthly surveillance activities are appropriate to the acuity, risk and needs of the residents. There have been no outbreaks. Infection types and numbers are entered into the ‘sway’ database, which generates a monthly analysis of the data. The analysis is reported to the monthly combined infection control and health and safety meetings. Infection control is discussed at clinical meetings and staff handovers. An infection control board has been set up for the display of topical infection control information and monthly graphs. An infection control audit in January 2015 had 100% compliance. Organisational benchmarking occurs against facilities of similar size. The previous CI remains. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There are policies around restraints and enablers. The service currently has six residents assessed as requiring the use of restraint (bed rails and lap belts) and three requiring enablers (bedrails only). Their care plans are up to date and provide the basis of factual information in assessing the risks of safety and the need for restraint. On-going consultation with the resident and family/whanau is also identified. Residents voluntarily request and consent to enabler use.  Staff received training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. |

# 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.7.5  A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Low | There is an annual education schedule that is being implemented and covers more than eight hours annually. In addition to mandatory training topics, opportunistic education is provided. Aged Care Education (ACE) is in place for the caregivers. Discussions with staff and management confirmed that a comprehensive in-service training programme in relevant aspects of care and support is in place. . | Annual performance appraisals have not been conducted annually in all five staff files reviewed. | Ensure staff appraisals are conducted annually.  180 days |
| Criterion 1.3.6.1  The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Low | Risk assessment tools for continence, falls, pressure area, pain and dietary profiles are reviewed at least six monthly or earlier for any changes in health status. Short term care plans were in place for short term/acute needs. Documented evidence of the residents’ current status and interventions were missing in two of the residents’ files reviewed. | The resident centred care plans for two hospital residents did not reflect the current status and interventions for (i) changes in dietary requirements and continuing weight loss and (ii) change in falls and pressure area risk. | Ensure care plans reflect the residents’ current health status and interventions.  90 days |

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

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

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

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

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End of the report.