# Summerset Care Limited - Summerset In The Sun

## 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 In The Sun

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

**Dates of audit:** Start date: 31 August 2015 End date: 31 August 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:** 42

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | 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 in the Sun provides rest home and hospital level care for up to 62 residents in the care centre (all dual-purpose beds) and rest home level care for up to 25 residents in the serviced apartments. On the day of audit, there were 31 residents in the care centre and eight rest home residents in the serviced apartments. Due to the current low demand for beds, the new wing (certified by HealthCERT 27 May 2015) has not yet opened.

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. 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.

There is an organisational risk management plan and a site-specific business plan 2014 – 2015. The quality and risk management plan is established. The service continues to be managed by a village manager who has been in the role for three years. The nurse manager is new to the facility and has been in the role for two months.

Two of the six shortfalls identified at the previous partial provisional have been addressed, including implementing a transition plan, and installation of handrails. Further improvements continue to be required around integration of notes, assessments, and care plan interventions. One improvement remains open due to the new wing not yet being opened.

This audit also identified improvements required around dating/signing of documentation, relative input into care planning, care plan evaluations and medication documentation.

## 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. |

Summerset in the Sun provides care in a way that focuses on the individual resident. Family are informed when resident health status changes. There is a documented process for making complaints and residents, family and staff interviewed are able to discuss the complaints process. Complaints are recorded on an electronic register that includes the complaint, action taken and sign-off.

## 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. |

Summerset in the Sun has an established quality and risk management system. Key components of the quality management system link to a number of meetings including monthly quality meetings. An annual resident satisfaction survey is completed and there are regular resident meetings. Quality performance is reported to staff at meetings and includes discussion about incidents, complaints, infections and internal audit results. The previous shortfall around a transition plan has been addressed. There are implemented human resources policies including recruitment, selection, orientation and staff training and development. The staffing policy aligns with contractual requirements and includes skill mixes.

## 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 medium or high risk and/or unattained and of low risk. |

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, care plans and evaluations are completed by the registered nurses. Risk assessment tools and monitoring forms are available. Short-term care plans are in use for changes in health status. There is a recreational therapist employed to develop and implement a Monday to Friday programme. The programme activities are meaningful and reflect ordinary patterns of life. There are outings into the community, volunteer involvement and visiting entertainers. There is an improvement required around delivery of the activity programme and activity care plans. There are medication management policies that are comprehensive and direct staff in terms of their responsibilities in each stage of medication management. Medication profiles are legible, up to date and reviewed by the general practitioner three monthly or earlier if necessary. There is an improvement required around competencies for self-medicating residents and medication competencies for caregivers. Food services policies and procedures are appropriate to the service setting. The food service is contracted to an external contractor. Resident's individual dietary needs are identified, documented and reviewed on a regular basis. Visual inspection of the kitchen shows evidence of compliance with current legislation and guidelines. Residents and family members interviewed were complimentary of the food service provided and report that individual preferences are well catered.

## 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. |

There is a building WOF which expires 27 January 2016. Planned and reactive maintenance systems are in place. The newly built wings in the care centre audited in April 2015 have not yet opened. Handrails have since been installed next to toilets in the ensuites of the new first floor wings.

## 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. |

There are documented policies and procedures around restraint use and use of enablers. Currently there is one resident using restraint and three residents with enablers. Staff training around the use of restraint and enablers is provided and staff interviewed understand the philosophy of minimal use.

## 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. |  | Standards applicable to this service fully attained. |

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Surveillance activities include audits of the facility, hand hygiene and surveillance of infection control events and infections. Staff receive on-going training in 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** | 0 | 12 | 0 | 4 | 3 | 0 | 0 |
| **Criteria** | 0 | 37 | 0 | 5 | 3 | 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. Complaint forms are available in locations accessible to residents and family. Information about complaints is provided on entry in the admission pack. Interviews with seven residents (three hospital and four rest home) and three family members confirmed their understanding of the complaints process. Staff interviewed (three registered nurses (RN) and three caregivers) were able to describe the process around reporting complaints.  Any complaints received are entered into the Summerset way system (Sway) which also alerts head office. 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. Six complaints received in 2015 (year to date) were managed within the required timeframes with evidence of comprehensive investigations undertaken by the village manager. All complaints have been resolved. |
| 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. There is an admission pack that gives a comprehensive range of information regarding the scope of service provided to the resident and their family/whānau on entry to the service. The pack includes a copy of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). This information is discussed at entry and staff are available whenever the resident and family members wish to discuss any aspect of service delivery. Family are involved in the initial care planning, and receive and provide ongoing feedback (link 1.3.3.4). Three family members (two hospital and one rest home) interviewed stated they were well informed. Resident/family meetings are held three monthly. Eight incident/accident forms were reviewed and all identified that the next of kin were contacted.  Residents and family state the service provides an environment that encourages open communication. Discussions with three caregivers identified their knowledge around open disclosure. The service has policies and procedures available for access to interpreter services and residents (and family) are provided with this information in resident information packs.  Residents and family members interviewed confirm the admission process and agreements documentation were discussed with them. |
| 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 in the Sun provides rest home and hospital level care for up to 62 residents in the care centre (all dual-purpose beds) and rest home level care for up to 25 residents in the serviced apartments. On the day of audit, there was 19 rest home (including two respite) and 12 hospital residents (including one respite) in the care centre and eight rest home residents in the serviced apartments. Due to current resident numbers being low, the new wing (certified by HealthCERT 27 May 2015) has not yet opened.  There is a risk management plan 2010 – 2015 (critical and severe risks) and a business plan 2014 – 2015. The business plan for Summerset in the Sun includes six business goals. A transition plan for the new wing has been completed (plan sighted); this is an improvement since previous partial provisional audit. The plan links to the current business plan 2014 – 2015.  The service is managed by a non-clinical village manager, who has been in the role for three years. He has a background in tourism/hospitality. The village manager is supported by the Summerset clinical quality manager and nurse manager. The nurse manager is new to the facility and has been in the role for two months. She has previous aged care experience, but not management experience in aged care. She has completed a postgraduate diploma in Gerontology. The management team confirmed that they believe there is more stability. The manager has maintained at least eight hours annually of professional development activities related to managing a hospital. The nurse manager has completed the Summerset orientation to the role. |
| 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 policy is in place that is reviewed annually. It is based on Summerset’s values and strategic plan. 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. Policies and procedures have been updated to reflect the implemented InterRAI procedures.  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. In February 2015, a peak in medication errors was noted. In-service training was conducted by Prices Pharmacy, plus discussions at handovers and RN meetings. Stats according were reduced the following months.  March /April 2015 – a peak in pressure injuries were reported. Additional in-service staff training was undertaken by Smith and Nephew and it resulted in reduction in pressure injuries.  A resident satisfaction survey is conducted each year. An annual internal audit schedule confirmed audits are being completed as per the schedule. Corrective actions are developed where opportunities for improvements are identified and are signed off when completed.  RNs are kept informed of quality and risk management activities, evidenced in the RN meeting minutes. There is a quality improvement meeting held monthly. A falls reduction strategic plan was sighted for the service. Sensor mats and physiotherapy services are utilised. Residents are checked regularly.  A health and safety representative has been identified for the service. Processes are in place for accident and incident reporting, injury prevention and management, workplace inspections and hazard management.  The Summerset group has a ‘clinical audit, training and compliance’ calendar. The calendar schedules the training and audit (et al) requirements for the month and the village manager completes a ‘best practice’ sheet confirming completion of requirements. The best practice sheet includes reporting including (but not limited to), meetings held, induction/orientation, audits, competencies, projects. The best practice sheet is sent to head office as part of the ongoing monitoring programme. |
| 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.  The service collects incident and accident data and reports aggregated figures monthly to the integrated meeting. Incident forms are completed by staff, the resident is reviewed by the registered nurse at the time of event and the form is forwarded to the nurse manager for review and final sign off. Family are notified. Eight incident forms were reviewed and all had been completed appropriately and signed. |
| 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. | FA | There are human resources policies to support recruitment practices. There are job descriptions available for all relevant positions that describe staff roles, responsibilities and accountabilities. A list of practising certificates is maintained. Five staff files were reviewed (one nurse manager, one registered nurse and three caregivers), all had relevant documentation relating to employment. Evidence of signed employment contracts, job descriptions, orientation, and training were sighted. Performance appraisals are due to be completed.  The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme includes documented competencies and induction checklists (sighted in files of newly appointed staff). Staff interviewed (three caregivers and three RNs) were able to describe the orientation process and believed new staff were adequately orientated to the service.  There is an annual education plan that is outlined on the ‘clinical audit, training and compliance calendar’. This includes all required education as part of these standards. A competency programme is in place with different requirements according to work type (eg, caregiver, registered nurse, and kitchen). Core competencies are completed and a record of completion is maintained on staff files and well as being scanned into ‘Sway’. Staff interviewed were aware of the requirement to complete competency training. Summerset employs a clinical education manager who is a registered nurse with a current practising certificate. The clinical education manager facilitates the orientation programme for new staff and supports the ongoing education programme. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | PA Low | The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. There are clear guidelines for increase in staffing depending on acuity of residents. There is 24 hour RN cover in the facility which includes at least one RN each shift. The roster considers the building design and a further nurses’ station is to be placed in the foyer area of the new upstairs wing when this wing is opened. Caregivers working the night shift are responsible for laundry services; however, morning caregivers interviewed reported they also complete laundry and they find both roles difficult. There is separate cleaning staff.  A caregiver is rostered 24/7 just for the rest home residents in the serviced apartments.  The previous partial attainment remains around opening of the new wing, as the wing has not yet opened. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | PA Low | Care plans and notes are legible. All resident records contain the name of resident. Entries are legible, but not always dated and signed by the relevant caregiver or registered nurse. Policies contain service name. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. |
| 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. | PA Moderate | The service medication policies and procedures follows recognised standards and guidelines for safe medicine management practice in accordance with the Medicines Care Guide for Residential Aged Care 2011. The facility uses two weekly supplied robotic sachets for regular and ‘as required’ medication delivered by the supplying pharmacy. Medications are checked against the signing sheets on arrival at the facility. Any discrepancies are fed back to the pharmacy.  All medications are kept in a locked trolley in the treatment room. The medication fridge temperature is recorded daily. A stock of hospital medications is kept in the medication room. Standing orders are documented but not dated. Locked drawers are available for those that choose to self-medicate. Three monthly reviews have not been completed for the one resident self-medicating.  All RNs that administer medication are competent and have received medication management training. Senior caregivers have received medication management training and have current competencies.  Ten resident medication charts sampled included photographs and allergy status. Shortfalls were identified around medication documentation. |
| 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 | There is a large kitchen and external contractors cook all food on site. There is a comprehensive kitchen manual in place. There is a qualified chef on duty Monday to Friday and two other cooks. They are supported by a morning and afternoon catering assistant. There is an eight week seasonal menu in place. The menu is reviewed annually. The chef receives a dietary profile for each resident with dietary requirements, special diets, food allergies, likes and dislikes. Alternatives are offered. The chef is notified of any dietary changes for the residents. Food is transported in hotboxes to the dining room where it is served from a bain marie. The upstairs dining area has a kitchenette. Special diets are plated and labelled. The fridge and freezer have visual temperatures, which are recorded daily. The facility fridges temperatures are monitored (records sighted). Temperature of food on delivery is recorded.  Feedback on the service and meals is by direct verbal feedback, residents comment book in the dining room (checked daily) and customer services.  There is a downstairs dining area for rest home residents in serviced apartments.  Staff working in the kitchen have food handling certificates and receive on-going training. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | PA Moderate | The previous two reports identified that assessments were not all completed. Four long-term resident files reviewed included gaps around assessments and InterRAI assessments. Clinical risk assessments including continence, safe handling, falls risk, pressure area risk, mini nutritional assessment, culture assessment, pain assessment, challenging behaviour and wound assessments are completed on admission, but not all reviewed at least six monthly. A challenging behaviour assessment has been completed for a resident with behaviours that challenge.  Respite file include an initial care plan and assessments. Pain assessments were completed in the files of residents with identified pain. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate | In two of five files reviewed, care plans included all interventions to support current needs. Residents interviewed stated their needs are being met. Relatives interviewed stated their relatives receive care within a timely manner and they are kept informed of any health changes, GP visits and care plan reviews.  Dressing supplies are available and a treatment room is stocked for use. Continence products are available and resident files include continence management. Specialist continence advice is available as needed and this could be described. Continence management in-services and wound management in-service have been provided.  There is a wound assessment and ongoing assessment and treatment plans in place for nine wounds reviewed. Incomplete records were identified in three wound management and evaluation charts.  Resident’s weights are recorded on admission and monthly thereafter, on the monthly weight chart. Where a risk is identified, care plans identified increase monitoring of weight and implementation of food/fluid charts. There were inconsistent records kept around weight documentation. |
| 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 | Five files reviewed included activity plans. Monthly progress notes are written. There is evidence of an implemented activities programme in all areas. The diversional therapist provides activities four days a week and a recreational therapist three days a week. Activities are planned that are appropriate to the functional capabilities of residents, taking into consideration physical and cognitive abilities and sensory impairment. One on one time is spent with hospital level residents or those who choose not to participate in the groups and includes reading/chats and pamper sessions. Residents go out to monthly community events. Special events, festive occasions and birthdays are celebrated. There are twice monthly church services on a rotation basis for the churches. Kindergarten and intermediate school children visit. There are two x weekly van outings and residents provide feedback and suggestions for the outings. There is a knitting circle, scrabble group and floral group. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Low | There is evidence of resident and family (where appropriate) involvement in MDT reviews (link 1.3.3.4). Four long-term care plans reviewed that had been with the service longer than six monthly did not have six monthly documented evaluations. There were short term care plans to focus on acute and short-term issues. These are reviewed daily by a registered nurse. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | There is a building WOF which expires 27 January 2016. Planned and reactive maintenance systems are in place and maintenance requests are generated through the on-line system using the Sway programme. There is a lift between the ground floor (care apartments) and the first floor (care centre). The maintenance person for Summerset in the Sun care centre and village is employed full-time and is available on call. A monthly maintenance schedule is generated on-line from head office and the maintenance person provides a monthly report. Hot water temperatures are recorded monthly and are consistently reading 42-45 degrees Celsius. Preferred contractors are available 24/7. There is adequate and safe storage of medical equipment. Corridors are wide enough in all areas to allow residents to pass each other safely with safe access to communal areas and outdoor areas. There is outdoor seating and shade and all areas are landscaped. There is a designated smoking area off the upstairs deck. The new wings in the care centre audited in April 2015 have not yet opened. Handrails have been installed next to toilets in the ensuites of the new first floor wings and this is an improvement on previous audit. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | Appropriate training, information, and equipment for responding to emergencies is provided. There is an approved evacuation plan (letter dated 20 December 2013). Fire evacuations are held six monthly and the last drill was completed 15 August 2015. Civil defence and emergency training was provided February 2015. There is staff across 24/7 with a current first aid certificate. There is a civil defence and emergency plan in place. |
| 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. | FA | Infection monitoring is the responsibility of the infection control coordinator. The infection control policy describes routine monthly infection surveillance and reporting. Responsibilities and assignments are described and documented. The surveillance activities at Summerset in the Sun are appropriate to the acuity, risk and needs of the residents. The infection control coordinator enters infections on to the infection register and into the ‘sway’ database, which generates a monthly analysis of the data. The analysis is reported to the monthly quality meetings (minutes viewed). |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. The policy includes comprehensive restraint procedures. A registered nurse is the restraint coordinator with a job description that defines the role and responsibilities. The policy identifies that restraint is used as a last resort. The service currently has three residents with enablers (bedrails) and one on restraint. There is provision for emergency restraint and the nurse manager is contacted for prior approval, for restraint to be implemented. There is a restraint committee (restraint coordinator, nurse manager and caregiver) that meet three monthly and report to the quality committee.  Enablers are voluntary and the least restrictive option. The resident and family have been provided with information on use of enablers; a consent form has been signed. Use of enabler and risks were documented in the long-term care plan of the enabler file reviewed. |

# 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 1.2.8.1  There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery. | PA Low | There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. There are clear guidelines for increase in staffing depending on acuity of residents. The previous partial provisional audit included ensuring staff were in place for the new wings (19 dual-purpose rooms). Advised, that this wing has not been opened as the demand for the beds is currently not there. Therefore, the previous finding has not been closed out. | The previous finding remains open as the new wing has not yet opened. (i) The current nurses’ station is a distance from the new upstairs wing. Advised that a small nurse’s station is to be placed at the start of the wing; (ii) Currently the night staff are responsible for laundry. Due to the size of the growing facility, this should be reviewed; Interviews with three caregivers confirmed difficulty with completing cares across the wing and going downstairs to do laundry; (iii) Staff have not yet been employed for the new dual purpose upstairs wing. | (i) Ensure a nurses station is installed as discussed prior to occupancy of this wing; (ii) Review responsibilities for laundry; (iii) Ensure appropriate trained staff in place for new wing prior to occupancy of residents within the upstairs wing.  Prior to occupancy days |
| Criterion 1.2.9.9  All records are legible and the name and designation of the service provider is identifiable. | PA Low | Care plans and notes are legible. All resident records contain the name of resident. Individual resident files did not always demonstrate service integration (link 1.3.3.4). Entries are legible, but not always dated and signed by the relevant caregiver or registered nurse. Policies contain service name. | ARC D7.1 Clinical records reviewed did not routinely have signatures of the writer or dates. | Ensure entries in resident files include dates, signature, and designation of the writer.  90 days |
| Criterion 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | The service medication policies and procedures follows recognised standards and guidelines for safe medicine management practice in accordance with the Medicines Care Guide for Residential Aged Care 2011. There is one locked medication room for the upstairs hospital/rest home and rest home residents in the serviced apartments. Ten resident medication charts sampled included photographs and allergy status. Shortfalls were identified around medication documentation. | The following documentation shortfalls were identified; (i) Three of 10 charts did not have ‘indications for use’ documented for ‘as required’ medication; (ii) One resident had two charts and therefore it was difficult to determine what is current; (iii) One signing sheet for a resident included different instructions for Novarapid and lorazepam than the medication chart. Noting the staff were administering the correct doses; (iv) Standing orders documented were not dated; (v) Pain assessments in the medication folders were not routinely completed. | (i) Ensure indications for use are documented for ‘as required’ medication; (ii) Ensure only current medication charts are kept with signing sheets; (iii) Ensure medication charts and signing sheets align; (iv) Ensure standing orders are signed and dated by GPs and evidence annual reviews; (v) Ensure pain assessment tools are utilised as per policy/procedure.  30 days |
| Criterion 1.3.12.5  The facilitation of safe self-administration of medicines by consumers where appropriate. | PA Low | There is a procedure that describes the management of self-medication. Locked drawers are available. Documentation reviewed for one resident self-medicating did not evidence three monthly reviews. | Three monthly reviews have not been completed for the one resident self-medicating. | Ensure self-medicating competencies are completed at least three monthly.  60 days |
| Criterion 1.3.3.4  The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate. | PA Low | Progress notes are maintained on every shift by caregivers or more often if there are any changes. RNs write in the medical continuation notes at least weekly and with significant events. Since previous audit, the RNs are now documenting in the progress notes and following through in a more methodical reporting manner. While progress notes have improved, overall integration of notes and links between notes is not always clear. Interviews with residents and relatives confirmed involvement in the assessment and care planning process. | (i) Five care plans reviewed did not evidence documented input from residents and relatives; (ii) Resident records are kept in a number of places including (but not limited to), STCPs in a separate folder, observations on computer or in files, InterRAI on computer. Registered nurses could not always locate records required. | (i) Ensure care plan documentation reflects input from residents/relatives; (ii) Review the current filing system to ensure integration of notes.  60 days |
| Criterion 1.3.4.2  The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning. | PA Moderate | The National Nurse Manager and the Clinical Education Manager (both senior registered nurses employed by Summerset to support and mentor staff) continue to provide additional support and education for all staff. The new clinical manager described reviewing documentation and following up with staff around incomplete documentation. There are currently four of six InterRAI trained nurses. While the RN could show InterRAI assessments completed on the computer, there was no evidence that these had been completed on resident files or links to current care plans. InterRAI assessments have not been completed for all new residents from 1 July 2015. | (i) One of two files (rest home) had no reassessments completed. (ii) Three (two hospital, one rest home) of four long-term residents reviewed had no InterRAI assessments or reassessments completed. (iii) Two (hospital) of four long term files had incomplete assessment booklets. | (i) Ensure reassessments are completed as per policy; (ii) & (iii) Ensure InterRAI assessments are completed for residents admitted from 1 July 2015 and when residents are due for reassessment.  60 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 Moderate | There were inconsistent records around weight documentation in all five files reviewed. The registered nurse showed that these were documented in various places, which made monitoring difficult to follow (link 1.3.3.4). Interventions reviewed identified those residents at risk were being monitored through hydration and food and fluid charts. Staff interviewed could describe current management of residents with weight loss.  There is a wound assessment and ongoing assessment and treatment plans in place for nine wounds (two skin tears, one laceration, one sinus, one ulcer, and four pressure areas (grade 2 & 3). There were photos and mapping grids utilised where applicable. Incomplete records were identified in three wound management and evaluation charts. There was documented evidence of district nurse involvement for one ulcer. Short-term care plans were in place for all but one pressure area. The file of one resident with two heel pressure areas was reviewed and subsequent recent acute admission to hospital. STCPs established for both pressure areas.  Care plans reviewed included all interventions to support current needs in two of five file sampled. | (1) There were inconsistent records around weight documentation in all five long-term files reviewed. (i) One hospital resident with identified weight loss. Records show resident weight last documented May 2015 (noting resident is on Ensure 5x daily, hydration chart was being completed and recent dietitian input noted). (ii) One rest home resident in serviced apartments was on daily weights post-acute visit to hospital, no records of daily weights could be located. (iii) One hospital resident admitted August had no weight documented on admission. (iv) One hospital resident on daily weights, but no records could be located. (v) Rest home resident weight chart stated last weight January 2015 39.9kg. Interventions state MNA to be completed monthly, last record February 2015.  (2) Inconsistency in wound management and evaluation records in three charts reviewed.  (3) Interventions were not documented for one resident (hospital tracer) with a pressure area on the ankle.  (4) One rest home resident (tracer) care plan lacked sufficient interventions to manage the risks around wandering. While a challenging behaviour assessment and management plan was in place, this was not dated or evaluated.  (5) One rest home resident on intermittent oxygen did not have this or supporting interventions to manage risk documented in the care plan. | (1) Ensure documentation reflects that weights are being monitored as required; (2) Ensure wound assessment, management and evaluation documentation is consistently completed; and (3) (4) (5) Ensure care plans include all interventions needed to support current needs.  60 days |
| Criterion 1.3.8.2  Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome. | PA Low | Two of six files reviewed had been with the service longer than six monthly. The sample was increased to four care plans that had been with the service for longer than six months. Care plan evaluations were not documented. However, MDT reviews were noted to be completed. | Four long-term care plans reviewed that had been with the service longer than six monthly, did not have six monthly documented evaluations. | Ensure documented care plan evaluations are completed at least six monthly.  60 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.