

Summerset Care Limited - Summerset By The Park

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](#).

The specifics of this audit included:

Legal entity:	Summerset Care Limited
Premises audited:	Summerset By The Park
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 30 October 2015 End date: 30 October 2015
Proposed changes to current services (if any):	
Total beds occupied across all premises included in the audit on the first day of the audit:	54

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

Indicator	Description	Definition
	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 by the Park provides rest home and hospital level care for up to 52 residents within the care centre and up to 58 rest home level of care residents in the serviced apartments. On the day of the audit, there were 48 residents in the care centre and six residents receiving rest home level of care in the serviced apartments.

The service is managed by a village manager/registered nurse who is supported by a regional operations manager, nurse manager, clinical nurse leader, registered nurses and care team.

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, relatives, management, general practitioner and staff.

One of the three previous findings from the certification audit around restraint monitoring has been addressed.

Improvement continues to be required around documented interventions and care plan timeframes.

No further shortfalls were identified.

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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The service practices open disclosure and the manager and the clinical nurse manager operate an open door policy. Families are informed of changes in resident's health status or incidents, in a timely manner. Interpreters are available if needed. The right of the consumer to make a complaint is understood, respected, and upheld. Complaints processes are implemented and complaints and concerns are managed and documented.

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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The Summerset group provides governance. The village manager ensures services are planned, coordinated and appropriate to the needs of the residents. There is an established, documented, and maintained quality and risk management system in place, which reflects continuous quality improvement principles. The system includes the management of the service according to the quality plan. The service has a range of policies and procedures that are aligned with current good practice and service delivery and are regularly reviewed. Incidents and accidents are managed according to policy. Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, residents. Corrective action plans are utilised to make quality improvements within the service. Actual and potential risks are identified, documented and where appropriate communicated to residents, their family/whānau of choice, visitors, and those commonly associated with providing services. Appropriate human resources are implemented and staff receive ongoing training. Staffing is appropriate to manage the needs of the residents.

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 registered nurses are responsible for each stage of provision of care and are required to complete assessments, resident centred care plans and evaluations. Risk assessment tools and monitoring forms are available for use. Resident centred care plans are individualised. Resident files evidence allied health involvement in the care of residents. Medical reviews are completed at least three monthly.

A diversional therapist and recreational therapist coordinate and implement a seven-day a week activity programme. Community links are maintained. There is volunteer involvement, visiting entertainers and outings.

Staff responsible for the administration of medications complete annual medication competencies and education. The service uses an electronic medication system.

The food service is contracted with all meals prepared on-site. Resident's individual dietary needs are identified and accommodated. Staff have attended food safety and hygiene training.

Safe and appropriate environment

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

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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There are documented policies and procedures around restraint use and use of enablers. There were two residents with restraints and two residents with enablers on the day of audit. The restraint coordinator and staff have received education on restraint minimisation and safe practice.

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.		Standards applicable to this service fully attained.
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The infection prevention and control programme includes the surveillance programme, which is managed by nurse manager with corporate oversight. There are established systems in place, which are appropriate to the needs of residents and visitors to the premises.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	15	0	2	0	0	0
Criteria	0	38	0	2	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>Nine staff (village manager, nurse manager, clinical nurse leader, two registered nurses and four caregivers), five residents (one rest home and four hospital level of care) and relatives (two hospital level of care) interviewed, were aware that residents and where applicable, their representatives have the right to make a complaint. There is an established complaint management system in place which includes complaints listed electronically in a master complaints register. There have been no serious consumer complaints received since the previous certification audit that required external notification.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	FA	<p>The service has policies and procedures in place to ensure that residents and their relatives are communicated with effectively. Staff practice open disclosure. Incident forms and progress notes sighted documented that regular contact is maintained with family including if an incident or care/health issues arises. Contact with family is recorded in the resident's clinical record and on the database. Family members interviewed state they are well informed and involved when needed in residents care. Records are kept of discussions with families. Interpreter services are available if needed. The content of the admission agreements complies with the requirements of the Aged Residential Care Agreement.</p>

conducive to effective communication.		
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Summerset by the Park provides 110 beds, which include 58 rest home beds in the serviced apartments (16 on level 3 and 42 on level 2) and 52 dual-purpose rooms located on the third floor in the care centre. On the day of audit, there were 12 rest home level residents and 40 hospital level residents in the 52 dual-purpose beds. One of the 12 rest home level residents in the care centre was receiving Primary Options for Acute Care (POAC) hospital level services. There were no residents on respite.</p> <p>The facility has been reconfigured twice since the previous audit. The reconfigurations involved the addition of one dual-purpose room in July 2014 and a change of one rest home room to a dual-purpose room in June 2015. However, the room has not yet been completely refurbished and the separate toilet/bathroom has not been completed as the service is awaiting council building consent to reconfigure the bathroom.</p> <p>The facility has commenced providing rest home level services in the level two serviced apartments since the previous audit. On the day of audit, there were six residents in the serviced apartments on level two, receiving rest home level care and two residents in the service apartments on level three receiving rest home level care.</p> <p>There is a retirement village attached as part of the complex with overall management of the site provided by the village manager.</p> <p>A strategic plan is in place for the organisation. An annual quality plan for the service is linked to the strategic plan and includes annual goals and objectives. The corporate clinical quality manager oversees quality.</p> <p>The village manager is a registered nurse (RN) with a current practising certificate, who has been employed by Summerset in the role since July 2014. She is an experienced facility manager having practised in aged care management for eight years and prior to that was employed within a district health board (DHB) in senior management roles.</p> <p>The nurse manager was appointed in June 2015. She is a registered nurse with a current practising certificate, who has been employed at a senior level in aged care in Australia for the last four years prior to this appointment. She has a nursing background in acute care. She has completed an orientation and medication competency assessment.</p> <p>A clinical nurse leader who has been in the position since September 2015, supports the nurse manager. The clinical nurse leader has practised in aged residential care in New Zealand at the same level for the last four years. She has completed an orientation and medication competency assessment.</p> <p>The village manager and the nurse manager have maintained at least eight hours of professional development activities related to managing an aged care facility, in the last 12 months.</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>A quality and risk management plan is in place. Policies and procedures reflect evidence of regular reviews as per the document control schedule. Policies and procedures have been updated to include reference to InterRAI processes. 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.</p> <p>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 Somerset facilities to identify trends. A resident satisfaction survey is conducted each year. Results for 2015 reflect resident satisfaction with the services received. An annual internal audit schedule is in place. 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.</p> <p>There is a current quality improvement in place related to falls management and improving the attendance at the group activities programme. The goal is to reduce the number of falls in the resident population and to maximise attendance in the activities programme, thereby improving staff observation.</p> <p>There is a health and safety programme in place, which involves hazard management. Hazard identification forms and a hazard register are in place. Hazards are listed at the entrance to the facility.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. The reporting system is integrated into the quality and risk management programme and is overseen by the corporate office. Once incidents and accidents are reported, the immediate actions taken are documented on incident forms. The nurse manager and/or village manager review and investigate incidents forms. Hazards are identified as appropriate. All 33 incident forms for the month of August 2015 were reviewed. Staff appropriately completed all incident forms reviewed. The village manager and the nurse manager understand their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required. The recent outbreak of Norovirus in September to October 2015 was notified to the DHB and the Public Health Officer who reported the outbreak to the Ministry of Health (email correspondence sighted).</p>
<p>Standard 1.2.7: Human Resource</p>	<p>FA</p>	<p>Human resources policies are implemented to meet the requirements of legislation. Prospective employees undergo reference checking, police vetting, and qualification checks (confirmed in review of five staff files, which</p>

<p>Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>included the nurse manager, the clinical nurse leader, the diversional therapist and two caregivers, all of whom were interviewed). New employees complete an orientation programme. The service employs nine RNs, including the nurse manager of who four are InterRAI competent, which enables the service to meet its InterRAI obligations. An annual in-service education programme is in place and a record of education attendance and achievement is maintained. Caregivers are encouraged and supported to achieve qualifications recognised by the New Zealand Qualifications Authority. RNs are supported to meet their professional development obligations including InterRAI training.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>The service has a documented rationale for determining staffing levels and skill mix for safe service delivery, based on the staffing standards and acuity. At least one RN is rostered to provide onsite care 24 hours a day, seven days a week. Staff interviewed reported that staffing levels and the skill mix was appropriate and safe. All residents are assigned a nominated caregiver on each of the three shifts. Assigned caregivers, who are currently based in the level three care centre, care for the rest home level residents in the serviced apartments on level two. The majority of the rest home residents in the serviced apartments are assigned to the same caregiver. There is separate staffing for residents living in the serviced apartments who are not receiving subsidised care. All families interviewed advised that they felt there was sufficient staffing.</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>	FA	<p>There are policies and procedures in place that follow recognised standards and guidelines for safe medicine management. The RNs and designated caregivers who are responsible for the administration of medications complete annual medication competencies and education. The service uses an electronic medication system. All incoming medications are checked against the medication charts. Standing orders are not used. There was a self-medication competency and monitoring in place for one rest home resident who was self-medicating.</p> <p>Ten resident medication charts (four rest home and six hospital) were reviewed. Medication charts on the electronic system have photograph identification and allergy status. The prescribing of regular and prn medications meets legislative requirements. Medication charts have been reviewed by the GP at least three monthly.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid</p>	FA	<p>The provision of meals is contracted, with all meals cooked on-site. The dietitian reviewed the summer menu in February 2015. Meals are transported in a bain marie to the dining rooms within the facility. There are alternative meal options available and resident likes/dislikes and preferences are known and accommodated. Special diets</p>

<p>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>include gluten free, vegetarian, texture modified and diabetic desserts. The chef manager receives a dietary profile for each resident and is notified of any dietary changes.</p> <p>The kitchen is well equipped with contracted service persons available 24 hours if required. The fridge, freezer, chiller and dishwasher have twice-daily temperatures recorded. End cooked food temperatures and bain marie pre-serving temperatures are recorded daily. Cleaning schedules are maintained. Chemicals are stored safely when not in use. Staff were observed wearing correct personal protective clothing.</p> <p>Staff working in the kitchen have food handling certificates and chemical safety training.</p> <p>Residents have the opportunity to feedback on food services through regular resident meetings. There are weekly village manager/chef manager meetings.</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 was documented evidence on the consultation record in resident files of relatives being informed of any health changes, GP visits and care plan reviews. When a resident's condition alters, the registered nurses initiate a review and if required, GP or specialist consultation.</p> <p>Dressing supplies are available and a treatment room 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.</p> <p>There were initial wound assessments and ongoing assessment and treatment plans in place for four skin tears, three minor wounds, one ulcerating wound and five pressures (three grade one and two grade two). Two pressure areas were present on resident admission. There is access to a wound nurse specialist if required.</p> <p>Interventions and monitoring has not been completed for three residents with health changes. The previous finding remains around interventions.</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</p>	<p>FA</p>	<p>The service employs a diversional therapist (DT) for 30 hours per week Tuesday to Saturday. A recreational therapist works Sunday to Thursday. There is an integrated rest home and hospital activity programme implemented seven days a week that meets the recreational preferences and abilities of the residents. The residents have choices of activities to attend. Volunteers are involved in many of the activities such as one on one visits, chats and pastoral visits.</p> <p>Community links are maintained through visiting school children, pet therapy, mobile library, church services, inter-home visits, women's and men's clubs and outings.</p> <p>Activity assessments and activity plans were completed in the resident files reviewed. Six monthly reviews were completed at the same time as the care plans.</p>

service.		Residents interviewed commented positively on the activities offered. Residents have the opportunity to provide feedback on the programme at the resident meetings.
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. Initial care plans for four residents were evaluated by the registered nurses within three weeks of admission (link 1.3.3) Care plans sampled were evaluated at least six monthly and updated as required to reflect the residents current health status. Written evaluations evidenced multidisciplinary team and resident/family involvement in the reviews. Short-term care plans sighted had been evaluated by the RN and either resolved or transferred to the long-term care plan for ongoing problems.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	Click here to enter text
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 prevention and control coordinator who is the nurse manager. 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 has been one outbreak of Norovirus since the previous audit, which was satisfactorily managed. Infection types and numbers are entered into an electronic database, which generates a monthly analysis of the data, which is benchmarked across the organisation. The statistics are reported to the monthly combined infection prevention and control, and health and safety meetings. Infection prevention and control matters are also discussed at clinical meetings and staff handovers.
Standard 2.1.1: Restraint	FA	There are policies around restraints and enablers that were last reviewed in March 2014. A registered nurse is the restraint coordinator. There were two residents using enablers and two residents using restraints on the day of

<p>minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>		<p>audit. The two files of residents using enablers evidenced voluntary consent and three monthly reviews.</p> <p>Staff, including the restraint coordinator, have received training around restraint minimisation and the management of challenging behaviour and completed restraint competencies.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>The files of the two residents on restraint were reviewed and evidenced restraint-monitoring forms in place. There was documented evidence of restraint monitoring occurring as identified in the restraint assessment including frequency of monitoring, duration of restraint episodes and cares provided during the restraint episode. The previous finding around restraint monitoring has been addressed.</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)
Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Low	Initial assessments had been completed for the five resident files reviewed. InterRAI assessments had been completed for all new admissions as from 1 July 2015 and for six monthly reviews as they became due. Four of five resident files sampled had the long-term resident centred care plan developed within three weeks of admission. Evaluations were completed for residents who had been at the service six months or earlier for health changes.	The long-term resident centred care plan for one rest home resident had not been developed within three weeks.	Ensure long-term care plans are developed within the required timeframe. 90 days
Criterion 1.3.6.1	PA Low	Risk assessment tools are completed on	1) There was no pain assessment or monitoring of the	1) and 2) Ensure

<p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>		<p>admission in the five resident files reviewed for identified risks/problems. Short-term care plans were in place for short term/acute needs. Monitoring forms were in place for behaviours, weight charts, bowel management and food and fluid intake.</p>	<p>effectiveness of pain relief for one hospital resident with identified pain and exacerbation of pain. 2) Another hospital resident did not have the pain assessment reviewed at the required frequency as documented in the long-term care plan; there was no monitoring of the effectiveness of pain relief. 3) There was no documented evidence of blood pressure monitoring as per GP instructions for one rest home resident. There were no documented interventions/monitoring for the same resident with altered mood.</p>	<p>pain assessments and monitoring requirements are implemented as per protocol. 3) Ensure GP instructions are implemented and interventions are documented for changes in health status.</p> <p>60 days</p>
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.