

Summerset Care Limited - Summerset in the Vines

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity: Summerset Care Limited

Premises audited: Summerset in the Vines

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

Dates of audit: Start date: 22 February 2016 End date: 23 February 2016

Proposed changes to current services (if any): Application has been made to Healthcert to increase the total number of beds from 41 to 42 dual purpose rooms. A conservatory lounge room has been converted to a bedroom occupied by a fulltime resident. The room was viewed during the audit and assessed as suitable for use as a dual purpose bedroom.

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

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

General overview of the audit

Summerset in the Vines provides rest home and hospital level care for up to 42 residents in the care centre. On the day of audit there were 42 residents.

The village manager is supported by an experienced nurse manager. The management team are also supported by the Summerset's regional manager, clinical educator and clinical and quality manager.

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

This audit identified improvements required around documented interventions, aspects of prescribing and activity plans.

The service has achieved a continuous improvement rating for reduction of falls and urinary tract infections.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Summerset in the Vines provides care in a way that focuses on the individual resident. There is a Māori health plan and cultural safety policy supporting practice. Cultural assessment is undertaken on admission and during the review processes. The service functions in a way that complies with the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and related services is readily available to residents and families. Policies are available that support residents' rights. Care plans accommodate the choices of residents and/or their family. Complaints processes are being implemented and complaints and concerns are managed and documented. Residents and family interviewed verified ongoing involvement with the community.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Summerset in the Vines has a well embedded quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to a number of meetings including monthly quality improvement meetings. Annual surveys and monthly resident meetings provide residents and families with an opportunity for feedback about the service. Quality performance is reported to staff at meetings and includes discussion about incidents, infections and internal audit results. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care. There is a staffing policy in place.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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The service has assessment processes and residents needs are assessed prior to entry. There is a well developed information pack available for residents and families/whānau at entry. Assessments, resident-centred care plans and evaluations were completed by the registered nurses within the required timeframes. Risk assessment tools and monitoring forms were available and implemented. Resident centred care plans were individualised.

An activity coordinator plans and implements an integrated activity programme. The activities meet the individual recreational needs and preferences of the consumer groups. There are outings into the community and visiting entertainers.

There are medicine management policies in place that meets legislative requirements. Staff responsible for the administration of medications completes annual medication competencies and education. The general practitioner reviews the medication charts three monthly.

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

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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There were documented processes for the management of waste and hazardous substances in place and incidents are reported in a timely manner. Chemicals were stored safely throughout the facility. The building has a current warrant of fitness. Resident bedrooms are spacious and personalised. There is a mix of bedrooms with ensuites or access to communal toilet/showers. There was sufficient space to allow the movement of residents around the facility using mobility aids or lazy-boy chairs. The hallways and communal areas were spacious and accessible. The outdoor areas were safe and easily accessible and provide seating and shade. The service has implemented policies and procedures for civil defence and other emergencies and six monthly fire drills are conducted. Housekeeping staff maintain a clean and tidy environment. All laundry and linen was completed on-site. There is plenty of natural light in all rooms and the environment is comfortable with adequate ventilation and heating.

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. The restraint coordinator is the nurse manager. The restraint committee meet three monthly to review restraint and enabler use. A restraint register is maintained. Staff have attended education on challenging behaviour and restraint minimisation. There were seven residents using restraint and one resident with an enabler.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.

All standards applicable to this service fully attained with some standards exceeded.

The infection control programme is appropriate for the size and complexity of the service. The infection control officer (RN) is responsible for coordinating/providing education and training for staff. The infection control officer had attended external training. The infection control manual outlined the scope of the programme and included a comprehensive range of policies and guidelines. The infection control officer uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This included audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Somerset facilities.

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	1	46	0	3	0	0	0
Criteria	2	96	0	3	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Discussions with staff (three care assistants, one registered nurse (RN), one clinical nurse leader, one property manager, one chef manager, one recreational therapist and one house keeper) confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Five residents (three rest home and two hospital) and four relatives (two rest home and two hospital) were interviewed and confirmed the services being provided are in line with the Code. Observation during the audit confirmed this in practice.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. Written general and specific consents were evident in the seven resident files (three rest home and four hospital level of care) reviewed. Caregivers and registered nurses interviewed confirm consent is obtained when delivering cares. Resuscitation orders had been appropriately signed by the resident and general practitioner. The service acknowledges the resident is for resuscitation in the absence of a signed directive by the resident. The general practitioner (GP) had discussed resuscitation with families/EPOA where the resident was deemed incompetent to make a decision.</p> <p>Discussion with family members identifies that the service actively involves them in decisions that affect their relative's lives. Seven admission agreements sighted were signed.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	Residents are provided with a copy of the Code on entry to the service. Residents interviewed confirmed they are aware of their right to access independent advocacy services and advocacy pamphlets are available at reception. Discussions with relatives confirmed the service provided opportunities for the family/enduring power of attorney (EPOA) to be involved in decisions. The resident files include information on residents' family/whānau and chosen social networks.
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. Activities programmes included opportunities to attend events outside of the facility including activities of daily living, for example, shopping and attending cafes and restaurants. Interview with staff, residents and relatives informed residents are supported and encouraged to remain involved in the community and external groups. Relative and friends are encouraged to be involved with the service and care.
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	The organisational complaints policy stated that the village manager has overall responsibility for ensuring all complaints (verbal or written) are fully documented and investigated. There is a complaints register that included relevant information regarding the complaint. The number of complaints received each month is reported monthly to staff via the various meetings. There were six complaints received in 2015 and 2016 (year to date). All of the complaints documentation included follow-up letters and resolutions were completed within the required timeframes. A complaints procedure is provided to residents within the information pack at entry. Feedback forms are available for residents/relatives in various places around the facility.
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	The service provides information to residents that include the Code, complaints and advocacy. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Residents and relatives interviewed identified they are well informed about the Code of Rights. Monthly resident meetings provide the opportunity to raise concerns. An annual residents/relatives survey is completed. Advocacy and Code of Rights information is included in the information pack and is available at reception.

<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Staff interviewed were able to describe the procedures for maintaining confidentiality of resident records, resident's privacy and dignity. House rules and a code of conduct are signed by staff at commencement of employment. Contact details of spiritual/religious advisors are available to staff. Resident files include cultural and spiritual values. Residents and relatives interviewed reported that residents are able to choose to engage in activities and access community resources. There is an abuse and neglect policy and staff education and training on abuse and neglect last occurred in July 2015.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>Summerset has a Maori health plan that includes a description of how they achieve the requirements set out in the contract. There are supporting policies and a specific Maori care plan available that enable recognition of Māori values and beliefs and identify culturally safe practices for Māori. Family/whanau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with disability and other community representative groups as requested by the resident/family. Cultural needs are addressed in the care plan. At the time of audit the staff reported there were no residents that identified as Maori. Staff education and training on cultural safety last occurred in May 2015.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>An initial care planning meeting is carried out with the resident and/or whānau as appropriate/able are invited to be involved. Individual beliefs or values are further discussed and incorporated into the care plan. Six monthly multi-disciplinary team meetings occur to assess if needs are being met. Family are invited to attend. Discussion with relatives confirms values and beliefs are considered. Residents interviewed confirm that staff take into account their culture and values.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from</p>	FA	<p>Staff job descriptions include responsibilities and staff sign a copy on employment. The quality improvement (full facility) meetings occur monthly and include discussions on professional boundaries and concerns as they arise. Management provide guidelines and mentoring for specific situations. Interviews with the nurse</p>

any discrimination, coercion, harassment, sexual, financial, or other exploitation.		manager and care assistants confirmed an awareness of professional boundaries. Professional boundaries training last occurred in December 2015.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	Residents and relatives interviewed spoke very positively about the care and support provided. Staff have a sound understanding of principles of aged care and state that they feel supported by the village manager and nurse manager. All Summerset facilities have a master copy of policies which have been developed in line with current accepted best practice and are reviewed regularly. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff. There is a quality improvement programme that includes performance monitoring against clinical indicators and benchmarking against like services within the group is undertaken. There is ongoing staff development with an in-service programme being implemented. There is evidence of education being supported outside of the training plan. Services are provided at Summerset that adhere to the Health & Disability services standards and all approved service standards are adhered to. There are implemented competencies for care assistants and registered nurses including but not limited to: insulin administration; medication; wound care and manual handling. RNs have access to external training.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents and family members stated they were welcomed on entry and were given time and explanation about services and procedures. Family members interviewed also stated they are informed of changes in the resident's health status and incidents/accidents. Resident/relative meetings are held monthly with an advocate from Age Concern present at the meeting every three months. The village manager and the nurse manager have an open door policy. The service produces a newsletter for residents and relatives. Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The service has policies and procedures available for access to interpreter services for residents (and their family/whānau).
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of	FA	The service provides care for up to 41 residents at hospital and rest home level care. On the day of the audit, there were 42 residents in total, 18 residents at rest home level and 24 residents at hospital level. All rooms are identified as dual purpose rooms. The service has made an application to HealthCERT for a conservatory lounge area to be used as a permanent bedroom. This was occupied on the day of audit. The room was viewed during the audit and verified as suitable for use as a dual purpose bedroom. There were no respite residents, younger person's or residents under the medical component of the certification. All residents were under the ARRC contract.

<p>consumers.</p>		<p>The Summerset Group Limited Board of Directors have overall financial and governance responsibility and there is a company strategic business plan in place. Summerset in the Vines has a site specific business plan and goals that is developed in consultation with the village manager, nurse manager and regional operations manager (ROM). The Summerset in the Vines quality plan is reviewed regularly throughout the year. There is a full evaluation at the end of the year. The 2015 evaluation was sighted.</p> <p>The village manager was away on the day of the audit. The village manager (non-clinical) has been in the role since August 2015 and has been with Summerset for a number of years prior. The village manager is supported by a nurse manager. The nurse manager has been in the position since September 2008 and has a considerable background in nursing and aged care. Village managers and nurse managers attend annual organisational forums and regional forums over two days. The nurse manager attends clinical education and forums/provider meetings at the Hawkes Bay District Health Board. There is a regional operations manager who is available to support the facility and staff.</p> <p>The village manager has attended at least eight hours of leadership professional development relevant to the role.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>During a temporary absence, the nurse manager will cover the manager's role. The regional operations manager and the clinical quality manager provide oversight and support. The audit confirmed the service has operational management strategies and a quality improvement programme to minimise risk of unwanted events.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement</p>	<p>FA</p>	<p>Summerset in the Vines is implementing the organisation's quality and risk management system. There are policies and procedures being implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed on a regular basis. The content of policy and procedures are detailed to allow effective implementation by staff.</p> <p>The Summerset group has a 'clinical audit, training and compliance' calendar. The calendar schedules the training and audit requirements for the month and the nurse manager completes a 'best practice' sheet confirming completion of requirements. The best practice sheet includes reporting about (but not limited to): meetings held, induction/orientation, audits, competencies and projects. The best practice sheet is sent to</p>

<p>principles.</p>		<p>head office as part of the ongoing monitoring programme.</p> <p>There is a meeting schedule including monthly quality improvement (full facility) meetings that includes discussion about clinical indicators (e.g. incident trends, infection rates). Registered nurse meetings are held monthly. Health and safety, infection control and restraint meetings occur three monthly. There are other meetings being held such as kitchen and activities. Resident/family meetings are held monthly with an advocate from Age Concern attending every three months. An annual residents/relatives survey completed (October 2015) reports overall 97% feedback of experience being good or very good. Summerset in the Vines achieved the number one position for Summerset as the best care home for 2015.</p> <p>The service is implementing an internal audit programme that includes aspects of clinical care. Issues arising from internal audits are developed into corrective action plans. Monthly and annual analysis of results is completed and provided across the organisation. There are monthly accident/incident benchmarking reports completed by the nurse manager that break down the data collected across the rest home and hospital and staff incidents/accidents. Infection control is also included as part of benchmarking across the organisation. Health and safety internal audits are completed. Summersets clinical and quality manager analyses data collected via the monthly reports and corrective actions are required based on benchmarking outcomes. Summerset has a data tool "Sway- the Summerset Way". Sway which is integrated and accommodates the data entered. There is a health and safety and risk management programmes in place including policies to guide practice. One of the registered nurses is the health and safety representative (interviewed). Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls. Reduction of falls was one of the key objectives of the service in 2015. The service has achieved a continuous improvement for reduction in falls rates.</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>Incident and accident data is collected and analysed. Discussions with the service confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Twelve resident related incident reports for January and February 2016 were reviewed. All reports and corresponding resident files reviewed evidence that appropriate clinical care has been provided following an incident. The incident reporting policy includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Data is linked to the organisation's benchmarking programme and used for comparative purposes (also link 1.2.3.6).</p>
<p>Standard 1.2.7: Human Resource Management</p>	<p>FA</p>	<p>There are human resources policies to support recruitment practices. A list of practising certificates is maintained. Seven staff files were reviewed (one nurse manager, one RN, one recreational therapist, one</p>

<p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>chef manager, one laundry and two care assistants). All had relevant documentation relating to employment. Performance appraisals are completed annually. 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 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. The plan is being implemented. A competency programme is in place with different requirements according to work type (e.g. care assistants, registered nurse and kitchen). Core competencies are completed and a record of completion is maintained on staff files as well as being scanned into 'Sway'.</p> <p>Staff interviewed were aware of the requirement to complete competency training. The nurse manager facilitates the orientation programme for new staff and supports the ongoing education programme. Care assistants complete an aged care programme.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The village manager and nurse manager work 40 hours per week Monday to Friday and are available on call for any emergency issues or clinical support. The service provides 24 hour RN cover. There are six care assistants on morning shift, five on the afternoon shift and two on the night shift. A staff availability list ensures that staff sickness and vacant shifts are covered. Care assistants interviewed confirmed that staff are replaced. Staffing levels and skills mix policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The resident files were appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access by being held in a locked cupboard. Care plans and notes were legible and where necessary signed (and dated) by a registered nurse. Entries are legible, dated and signed by the relevant care assistant or registered nurse including designation. Individual resident files demonstrate service integration. There is an allied health section that contained general practitioner notes and the notes of allied health professionals and specialists involved in the care of the resident.</p>
<p>Standard 1.3.1: Entry To Services</p>	<p>FA</p>	<p>All residents have a needs assessment completed prior to entry that identifies the level of care required. The nurse manager screens all potential enquiries to ensure the service can meet the required level of care and</p>

<p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>		<p>specific needs of the resident.</p> <p>Residents and relatives interviewed stated that they received sufficient information on admission and discussion was held regarding the admission agreement. The admission agreement reviewed aligns with a) - k) of the ARRC contract.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>There is an exit, discharge and transfer policy that describes guidelines for death, discharge, transfer, documentation and follow up. All relevant information is documented and communicated to the receiving health provider or service. Follow up occurs to check that the resident is settled or, in the case of death, communication with the family is made.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Low</p>	<p>There are medicine management policies and procedures that align with recognised standards and guidelines for safe medicine management practice in accordance with the Medicines Care Guide for Residential Aged Care 2011. RNs are responsible for the administration of medications in the rest home/hospital care centre. Senior care assistants complete competencies for the checking and witnessing of medications as required. Medication competencies and education has been completed annually. All medications delivered were evidenced to be checked on delivery with any discrepancies fed back to the supplying pharmacy. The service implemented an electronic medication system in November 2015. Standing orders are not used. There was one resident self-medicating an inhaler on the day of audit. Self-medicating competency had been completed and signed by the resident, GP and RN. Self-medication competencies are reviewed three monthly.</p> <p>Fourteen resident medication charts on the electronic medication system were reviewed (seven rest home and seven hospital). The charts had photograph identification and allergy status recorded. A shortfall was identified around the prescribing of a dietary supplement and 'indications for use' for 'as required' medication. Staff recorded the time and date of 'as required' medications. The nurse manager monitors missed medications.</p> <p>All 14 medication charts reviewed identified that the GP had reviewed the medication chart three monthly.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p>	<p>FA</p>	<p>Medirest is contracted for the provision of meals on-site. There is an eight week rotating menu approved by the dietitian. The chef manager is supported by a weekend cook and team of kitchen hands. Resident likes/dislikes and preferences are known and accommodated with alternative meal options. The kitchen is adjacent to the dining room. Meals are served from the bain marie to residents in the dining room. Texture</p>

<p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>modified meals, fortified foods and diabetic desserts are provided. The cook receives a dietary profile for each resident.</p> <p>The fridge, freezer and dishwasher have daily temperatures recorded. End cooked food temperatures are recorded twice daily. All foods are stored correctly and date labelled. Cleaning schedules are maintained. Chemicals are stored safely within the kitchen. Staff were observed wearing correct personal protective clothing when entering the kitchen. The chemical provider completes a functional test on the dishwasher monthly.</p> <p>Staff working in the kitchen have food handling certificates and chemical safety training.</p> <p>Residents commented positively on the meals provided. The chef manager attends the resident meetings and welcomes feedback on the meal service.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>The reason for declining service entry to residents should this occur is communicated to the resident or family/whānau and they are referred to the original referral agent for further information.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>The initial support plan is developed with information from the initial assessment. Clinical risk assessments are completed on admission where applicable and reviewed six monthly as part of the interRAI assessment. Outcomes of risk assessment tools are used to identify the needs, supports and interventions required to meet resident goals. The interRAI assessment tool has been utilised for all residents.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote</p>	<p>FA</p>	<p>Resident centred care plans describe the individual support and interventions required to meet the resident goals. The care plans reflect the outcomes of risk assessment tools. Care plans demonstrate service integration and include input from allied health practitioners.</p> <p>Short-term care plans were in use for changes in health status. These are evaluated regularly and either resolved or if an ongoing problem, added to the long term care plan. There is documented evidence of</p>

continuity of service delivery.		resident/family involvement in the care planning process. Residents/relatives interviewed confirmed they participate in the care planning process.
<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>	PA Low	<p>When a resident's condition changes, the RN initiates a review and if required, a GP or nurse specialist consultation. Relatives interviewed state their relatives needs are met and they are kept informed of any health changes. There was documented evidence in the resident files of family notification of any changes to health including infections, accidents/incidents and medication changes. Residents interviewed state their needs are being met.</p> <p>Adequate dressing supplies were sighted. Initial wound assessments with ongoing wound evaluations and treatment plans were in place for 13 minor wounds, one chronic ulcer and two grade 4 pressure injuries (one non-facility acquired and one facility acquired.). Wounds reviewed have been re-assessed at least monthly. Evaluation comments were documented at each dressing change to monitor the healing progress. Photographs evidenced healing progress. The RN and nurse manager confirmed there was a wound nurse specialist available and who is involved in pressure injury management. The District Health Board engage team (wound nurse specialist, occupational therapist and pharmacist) and the wound clinic nurses have been involved in the treatment of both pressure injuries.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed.</p> <p>There are a number of monitoring forms and charts available for use. RNs review the forms/charts and completed risk assessments for any changes to health status. Not all care plan interventions meet the resident's current needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	PA Low	<p>The service employs a recreational therapist (RT) who is a qualified caregiver. The integrated rest home and hospital programme covers seven days a week. Currently a care assistant coordinates weekend activities. The RT attends regional diversional therapy workshops and attends Somerset conference calls for all activity persons.</p> <p>The programme is planned a month in advance and includes set activities with the flexibility to add other activities of interest or suggestions made by residents. Activities meet the recreational needs of both resident groups. By ensuring all residents have the opportunity for outings, shopping and attending community groups/events including concerts, art deco functions and RSA lunches. Community visitors include day care and schoolchildren, dance groups, entertainers and a work experience student. Residents are encouraged to maintain their former community links. Church services are held fortnightly.</p>

		<p>The service has a wheelchair van for the twice weekly outings for rest home and hospital residents. The driver has a current first aid certificate.</p> <p>Monthly meetings provide an opportunity for residents to feedback on the programme. Newsletters are sent out to families informing them of upcoming events and are invited to attend.</p> <p>The RT is involved in the multidisciplinary review which includes the resident's participation in activities. Individual activity plans were not completed in all resident files reviewed.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>There is evidence of resident and family involvement in the review of resident centred care plans. All initial care plans were evaluated by the registered nurses within three weeks of admission. Written evaluations were completed six monthly or earlier for resident health changes in all files reviewed. There is evidence of multidisciplinary (MDT) team involvement in the reviews including input from the GP and any allied health professionals involved in the resident's care. Families are invited to attend the MDT review and asked for input if they are unable to attend. Short-term care plans sighted have been evaluated by the RN. The GP completes three monthly reviews.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Referral to other Health and Disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The service provided examples of where a resident's condition had changed and the resident was reassessed for a higher level of care.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are</p>	FA	<p>Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Safety data sheets were readily accessible for staff. Chemicals were stored safely throughout the facility. Personal protective clothing was available for staff and seen to be worn by staff when carrying out their duties on the day of audit. Relevant staff have completed chemical safety training.</p>

<p>protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>		
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building has a current building warrant of fitness that expires on 26 February 2016. There is a full time property manager who oversees the property and gardening team and is available on call for facility matters. Planned and reactive maintenance systems are in place and maintenance requests are generated through the Sway (Summerset way) on-line system (property services requests). All electrical equipment has been tested and tagged. Clinical equipment has had functional checks/calibration annually. Hot water temperatures have been tested and recorded monthly with readings between 42-45 degrees Celsius. Corrective actions have been recorded for temperatures outside of the acceptable range. Preferred contractors for essential services are available 24/7.</p> <p>Corridors are wide in all areas to allow residents to pass each other safely. There is safe access to all communal areas and outdoor areas. There is outdoor seating and shade. The external areas are well maintained.</p> <p>The care assistants and registered nurses (interviewed) state they have all the equipment required to safely provide the care documented in the care plans.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>Visual inspection evidences toilet and shower facilities are of an appropriate design to meet the needs of the residents. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. All bedrooms have a hand basin. Nine bedrooms have en-suites. There are adequate numbers of communal toilets and showers. Communal toilet/shower facilities have a system that indicates if it is engaged or vacant.</p>

<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>There is adequate room to safely manoeuvre mobility aids and transferring equipment such as hoists in the residents' bedrooms. The doors are wide enough for ambulance trolley access. Residents and families are encouraged to personalise their rooms as viewed on the day of audit. One spacious conservatory lounge room has been permanently converted to a bedroom. The bedroom is suitable for rest home or hospital level of care. The fire service approved the use of the conservatory as a bedroom in July 2013 when it was used as a respite room for the village residents.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>Communal areas within the facility include a large main lounge that can accommodate rest home and hospital level residents and where most activities take place. There is a smaller lounge at the end of one wing of bedrooms where individual or small group activities occurs such as reading, knitting and cards. There is another conservatory lounge at the end of another wing of bedrooms and a sunroom/lounge off the dining room. The dining room is spacious enough to accommodate hospital recliners if necessary. There are several seating alcoves within the facility. The communal areas are easily accessible for residents.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. All linen and personal clothing is laundered on-site. The laundry service operates in the laundry during the night with the third caregiver on night duty completing laundry duties. The laundry has defined clean/dirty areas and an entry and exit door. There is a sluice area in the laundry with personal protective equipment available. There is dedicated housekeeping staff seven days a week. Cleaning trolleys sighted were well equipped and are kept in designated locked cupboards when not in use. External (chemical provider) and internal audits monitor the effectiveness of laundry and cleaning processes.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security</p>	<p>FA</p>	<p>There are emergency and disaster manuals to guide staff in managing emergencies and disasters. Emergencies, first aid and CPR are included in the mandatory in-service programme. There is a first aid trained staff member on every shift. Summerset in the Vines has an approved emergency and management plan. A NZ Fire letter dated 9 July 2013 confirmed that the conservatory lounge room complied with the fire safety and evacuation of buildings regulations 2008. The fire service first approved the use of the conservatory as a bedroom in July 2013 when it was used as a respite room for the village residents. Fire drills occurs six monthly and the last fire drill occurred in August 2015. Smoke alarms, sprinkler system and exit signs are in place. The service has alternative cooking facilities (BBQ) available in the event of a power</p>

situations.		failure. Emergency lighting is in place for four hours. There are three civil defence kits in the facility and 2,500 litres of stored water. Call bells are evident in resident's rooms, lounge areas, toilets/bathrooms and the additional bedroom. The facility is secured at night.
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	Visual inspection evidences that the residents have adequate natural light in the bedrooms and communal rooms, safe ventilation and an environment that is maintained at a safe and comfortable temperature.
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The infection control programme is appropriate for the size and complexity of the service. There is an infection control responsibility policy that includes responsibilities for the infection control officer. The infection control officer (RN) has a signed job description. The infection control programme is linked into the quality management system and reviewed annually at head office in consultation with infection control officers. The facility meetings include a discussion of infection control matters. Infection control goals include reducing the annual infection events below 60.</p> <p>Visitors are asked not to visit if they are unwell. Influenza vaccines are offered to residents and staff. Hand sanitizers are available throughout the facility</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the</p>	FA	<p>The infection control officer attends the annual Summerset training day for infection control officers. She also attends the two monthly DHB infection control support group meetings. The infection control officer supports infection control officers at new Summerset sites. The infection control officer has attended external training in November 2014.</p> <p>The infection control committee comprises of a cross section of staff from areas of the service. The infection control committee meets quarterly and infection events are forwarded to head office for benchmarking.</p> <p>The facility has access to an infection control nurse specialist at the DHB, public health, laboratory, GP's and expertise within the organisation.</p>

organisation.		
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>There were comprehensive infection control policies that were current and reflected the Infection Control Standard SNZ HB 8134:2008, legislation and good practice. These are across the Summerset organisation and were reviewed last in September 2014. The infection control policies link to other documentation and cross reference where appropriate.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control officer is responsible for coordinating and providing education and training to staff. The induction package includes specific training around hand washing competencies and standard precautions. Ongoing training occurs annually as part of the training calendar set at head office.</p> <p>Resident education occurs as part of providing daily cares. Care plans can include ways to assist staff in ensuring this occurs</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	CI	<p>The infection control policy includes a surveillance policy including a surveillance procedure, process for detection of infection, infections under surveillance, outbreaks and quality and risk management. Infection events are collected monthly and entered onto the SWAY electronic system. The facility is benchmarked against other Summerset facilities of similar size and benchmarking results are fed back to the infection control officer and used to identify areas for improvement. Infection control audits are completed and corrective actions are signed off (sighted). Surveillance results are used to identify infection control activities and education needs within the facility.</p> <p>There have been no outbreaks.</p>

<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>There are policies around restraint, enablers and the management of challenging behaviours which meet requirements of HDSS 2008. Policy dictates that enablers should be voluntary and the least restrictive option possible. The service currently has seven hospital residents with restraint and one rest home resident using an enabler. The three resident files (two restraint and one enabler) sampled reflect the use of restraint/enabler, have signed consents and risks identified with the use of the restraint/enablers are identified in the care plan. The service applies the same policies/procedure for restraint and enablers. The service has been proactive in trying to reduce restraint and enabler use and implemented a quality goal/improvement plan.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>Responsibilities and accountabilities for restraint are outlined in the restraint coordinators job description. The restraint coordinator is the nurse manager and has been in the position for three years. The restraint committee meet three monthly and discuss all residents using restraints or enablers. The resident (if appropriate) and relatives receive information on the use of restraints. Restraints are reviewed at a frequency as determined by organisational restraint minimisation policy and resident safety. Three files reviewed evidenced consent forms completed.</p> <p>Restraint education is included in care staff orientation. Ongoing education is provided and staff complete restraint competencies.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>Summerset restraint minimisation policy outlines the organisation approach to managing restraint. This includes the use of a restraint assessment guide by the restraint coordinator and GP. Three files reviewed, documented an in-depth assessment including the consideration of alternatives prior to application of restraint/enabler.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>Restraint policy states that the need for restraint use is monitored and reviewed as part of the six monthly reviews. Restraints have been evaluated monthly by the nurse manager (restraint coordinator). The service reviews all restraint use as part of the monthly quality meetings. Restraint monitoring and frequency is carried out as directed and includes documentation of the cares delivered to the resident during each episode of restraint. Restraint use is discussed at clinical meetings. Restraint is only used at the service as a last resort</p>

		after all other alternative techniques to modify behaviour or manage resident safety has been exhausted. This is outlined as policy requirements in the restraint minimisation policy. There is a restraint/enabler register which is to be updated by the restraint coordinator as required and at least monthly.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The service has documented evaluation of restraint every three months. In the files reviewed, evaluations had been completed with the resident, family/whānau, restraint coordinator and medical practitioner. Restraint practices are reviewed on a formal basis every month by the facility restraint coordinator at quality and staff meetings. Evaluation timeframes are determined by risk levels.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The service reviews restraint use as part of its internal audit processes. The results of the restraint audit are discussed at the monthly quality meetings and any corrective actions identified are actioned through this forum.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.12.1</p> <p>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.</p>	PA Low	Thirteen medication charts met the legislative prescribing requirements for regular medications. Twelve of fourteen medication charts had the indication for use for ‘as required’ medications.	(i) A regular dietary supplement (for one rest home resident with weight loss) was incorrectly prescribed under the ‘as required’ medications. The dietary supplement had not been dispensed and therefore not administered for six days. (ii) Two out of fourteen medications charts did not have the ‘indication for use’ documented for ‘as required’ restricted medications.	(i)& (ii) Ensure medications are charted to meet legislation and guidelines 30 days
<p>Criterion 1.3.6.1</p> <p>The provision of services</p>	PA Low	There are a number of monitoring forms and charts available for use including	(i) Dietary requirement identified in the interRAI assessment tool for one rest home resident were	Ensure documented

and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.		(but not limited to) pain monitoring, restraint, blood sugar levels, weight, wound evaluations, food and fluid intake and repositioning charts. RNs review the forms/charts and completed risk assessments for any changes to health status. Not all care plan interventions meets the resident's current needs.	not reflected in the long term care plan (link rest home tracer). (ii) Rest home resident at risk of pressure injury with oedema of legs did not have GP instructions documented for elevation of legs in the care plan, and (iii) one hospital level insulin dependent resident did not have a documented diabetic management plan that included signs, symptoms and blood sugar levels for treatment.	interventions reflect the resident's current health status. 90 days
Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	PA Low	An individual recreational assessment is completed for each resident on admission that identifies community links, hobbies and interests. Individual activity plans had been completed in one of three rest home files and two of four hospital resident files. Monthly activity progress notes had been maintained for each resident.	Individual activity plans had not been completed for two rest home residents and two hospital residents.	Ensure all residents have an individual activity plan. 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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	CI	Summerset in the Vines is proactive around following through and identifying quality improvements from internal audits, incidents/accidents and complaints. QI corrective action plans (CAP) are established when above the benchmark. Quality action forms are also established for areas that staff/management identify as requiring improvement. As part of Summersets commitment to improving resident care and support, Summerset in the Vines has a “do no harm” component of the KPI (key performance indicators). Goals to reduce the number of falls and reduction of facility acquired pressure injuries below the organisational KPI.	<p>A quality action plan was implemented in April 2015 to reduce resident falls by 20% by June 2016. The objective was established in respect of quality data analysis. The intent of the objective was to reduce the number of resident falls. Implementation included a falls programme to ensure that all residents were walked on a regular basis.</p> <p>Proactive falls prevention goals were implemented, including a) vitamin D plan for 90% of residents, b) ensuring all rooms were clutter free and surplus items put away at night, c) regular monitoring of resident call bells to ensure they are within reach and answered promptly, d) beds at the lowest level with brakes on at all times, e) appropriate well-fitting footwear is worn by residents when mobilising, f) when a fall occurs, staff place a dot on the site map on the staff notice board to denote where the fall occurred, the area then has to be checked for any hazards, g) sensor mats used for residents who are identified as frequent fallers, and h) all residents to be toileted four hourly.</p> <p>Progress toward the achievement of these goals was communicated at resident and staff meetings and updates placed on site notice boards. CAPS were reviewed monthly at staff meetings and the monthly indicator data was</p>

		Reduction of falls is one KPI.	analysed and discussed. Somerset in the Vines has successfully reduced all falls over a period from April 2015 to January 2016. All falls statistics for April 2015 were at 6.78 and in January 2016 were at 5.79.
Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.	CI	The infection control officer provides infection control data, trends and relevant information to the infection control committee and clinical/quality meetings. Areas for improvement are identified, corrective actions developed and followed-up. The service identified an improvement to reduce the number of urinary tracts infections (UTI) below the organisational benchmark. A project to reduce UTIs commenced May 2015 with the number of UTIs below the benchmark for the last six months.	A project to reduce UTIs commenced May 2015 with the number of UTIs below the benchmark for the last six months. An action plan was developed that included additional and alternative fluids plan such as jellies, instant puddings and ice blocks for residents with an estimated intake of 1500mls in 24 hours for each resident. The infection control officer provided education to all staff on the anatomy and physiology of the urinary tract and fluid therapy. All staff are involved in offering fluids. Families and residents were involved in the project and received explanations and education on reducing UTIs and the preventative plan. The infection control officer identified through surveillance data that some residents were prone to UTIs and researched the use of Hiprex. In consultation with the GP, a criteria was set for commencing residents on Hiprex and/or cranberry. The criteria was residents with three UTIs in a six month period. The action plan and surveillance data for UTIs was reviewed monthly by the infection control officer and three monthly by the infection control committee. The infection control data for UTIs have reduced below the organisational benchmark for the last six months. One resident prone to UTIs was commenced on Hiprex September 2015 and has had one UTI in January 2016. The service has been successful in reducing UTIs.

End of the report.