

Summerset Care Limited - Summerset in the Bay

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 Bay
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 29 February 2016 End date: 1 March 2016
Proposed changes to current services (if any):	
Total beds occupied across all premises included in the audit on the first day of the audit:	48

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

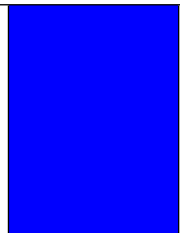
Summerset in the Bay provides rest home and hospital level care for up to 48 residents. On the day of the audit there were 44 residents. The service is managed by a village manager and a nurse manager. The residents and relatives interviewed spoke positively about the care and support provided.

This 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.

The village manager is appropriately qualified and experienced and is supported by a nurse manager (registered nurse) who oversees the care centre. There are quality systems and processes being implemented. The service has been actively working on reducing turnover of staff and improving communication with service users. An induction and in-service training programme is in place to provide staff with appropriate knowledge and skills to deliver care.


The service is commended for achieving two continued improvement ratings around good practice and quality projects.

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

Summerset in the Bay 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 process. 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.
---	--	--

Summerset in the Bay 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.		Standards applicable to this service fully attained.
--	--	--

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, interventions 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 and reflected the resident's current needs and supports.

A diversional therapist coordinates and implements an integrated activity programme. She is supported by a part-time recreational therapist. 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 complete annual medication competencies and education. The general practitioner reviews the medication charts three monthly.

The food service is contracted to an external 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.
--	--	--

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 are bedrooms with ensuites and some closely located 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. Six monthly fire drills are conducted. Housekeeping/laundry staff maintains 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.
---	--	--

Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort. The service currently has four residents assessed as requiring the use of restraint (three bed rails and one lap belt) and one requiring enablers (bedrails only). Staff receive regular education and training on restraint minimisation.

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.

The infection control programme is appropriate for the size and complexity of the service. The infection control officer (RN/clinical nurse leader) is responsible for coordinating and providing education and training for staff. The infection control officer has 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	49	0	0	0	0	0
Criteria	2	99	0	0	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 10 staff (three care assistants, two registered nurses (RN), one property manager, one chef manager, two housekeepers and one diversional therapist) confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Seven residents (four rest home and three hospital level of care) and two relatives (rest home) 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 were discussed with residents and families on admission. Written general and specific consents were evident in the seven resident files (three hospital and four rest home 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 (two rest home) 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 states that the village manager has overall responsible for ensuring all complaints (verbal or written) are fully documented and investigated. There is a complaints register that included relevant information regarding the complaint. Documentation included follow-up letters and resolution. The number of complaints received each month is reported monthly to staff via the various meetings. There were eight 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. 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 elder abuse and neglect policy. 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 Māori health plan that includes a description of how they achieve the requirements set out in the contract. There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. Family/whānau 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. Staff interviewed were able to describe how they can ensure they meet the cultural needs of residents identifying as Māori.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>An initial care planning meeting is carried out where the resident and/or 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 any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Staff job descriptions include responsibilities and staff sign a copy on employment. The 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 village manager, nurse manager and registered nurses confirmed an awareness of professional boundaries. Care assistants discussed professional boundaries and attended training in December 2015.</p>

<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>CI</p>	<p>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.</p> <p>All Summerset facilities have a master copy of policies which have been developed in line with current accepted best practice and are reviewed regularly. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff. 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 a culture of 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 adheres to the Health & Disability services standards. 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.</p> <p>The service has evidenced good practice and achieved a continuous improvement around weight loss management and reduction of incidents relating to bruises.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>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). If residents or family/whānau have difficulty with written or spoken English, the interpreter services are made available.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The service provides care for up to 48 residents at hospital and rest home level care. On the day of the audit, there were 44 residents in total, 29 residents at rest home level including one respite care resident and 15 residents at hospital level. There were no younger people or residents under the medical component of the certification. All residents were under the ARC contract. The Summerset Group Limited Board of Directors have overall financial and governance responsibility and there is a company strategic business plan in place.</p> <p>Summerset in the Bay 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 Bay</p>

		<p>quality plan is reviewed regularly throughout the year. There is a full evaluation at the end of the year. The 2015 evaluation was sighted. The village manager has been in the current role at Summerset since May 2015 and has been with Summerset for four years. The village manager is supported by a nurse manager. The nurse manager has been in the position for three years and has a background in aged care nursing. 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. 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>	FA	<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 principles.</p>	FA	<p>Summerset in the Bay 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 reports (but not limited to): meetings held, induction/orientation, audits, competencies and projects. This is forwarded to 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 facility meetings held, such as kitchen and activities. An annual residents/relatives survey completed (October 2015) reports overall 98% feedback of experience being good or very good.</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 Somerset Way". Sway is integrated and accommodates the data entered. There is a health and safety and risk management programme 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.</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>	FA	<p>Incident and accident data has been 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 February 2016 were reviewed (seven falls, four skin tears and one other category). 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.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are human resources policies to support recruitment practices. A list of practising certificates is maintained. Seven staff files (one nurse manager, one RN, one clinical nurse manager, one activities coordinator, one property manager and two caregivers) were reviewed and all had relevant documentation relating to employment. Performance appraisals had been 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'. 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 and well as being scanned into 'Sway'.</p>

		Staff interviewed were aware of the requirement to complete competency training. Care assistants complete an aged care programme.
<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	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. There are six care assistants on morning shifts, six on the afternoon shifts and two on night shifts. 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>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	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>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>All residents have a needs assessment completed prior to entry that identifies the level of care required. The nurse manager screens all potential enquiries to ensure the service can meet the required level of care and specific needs of the resident.</p> <p>Residents (four rest home and one hospital) 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 ARC contract.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated</p>	FA	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.

transition, exit, discharge, or transfer from services.		
<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 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 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 were two rest home residents self-medicating 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 (eight rest home and six hospital). The charts had photograph identification and allergy status recorded. Staff recorded the time and date of 'as required' medications. The nurse manager monitors missed medications. All fourteen medication charts reviewed identified that the GP had reviewed the medication chart three monthly.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>Medirest is contracted for the provision of meals on-site. There is an eight week rotating menu approved by the dietitian. The menu includes resident preferences. The chef manager (interviewed) is notified of any changes to resident's dietary requirements. Resident likes/dislikes and preferences are known and accommodated with alternative meal options. Food is delivered in hot boxes to the dining room kitchenette where meals are served from the bain marie. Special requests and alternative meals are plated and labelled. Texture modified meals, fortified foods, protein drinks and diabetic desserts are provided. The cook receives a dietary profile for each resident.</p> <p>The fridge and freezer have twice 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 receives feedback from resident meetings and welcomes suggestions on the meal service. The "happy or not" survey has been</p>

		implemented to identify areas of improvement in the meal service.
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	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>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	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>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Resident centred care plans describe the individual support and interventions required to meet the resident's 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 resident/family involvement in the care planning process. Residents/relatives interviewed confirmed they participate in the care planning process.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<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 ten minor wounds, three chronic wounds and three grade II pressure</p>

		<p>injuries (all facility acquired.). Wounds are re-assessed at least monthly. Evaluation comments were documented at each dressing change to monitor the healing progress. The RN and nurse manager confirmed there was a wound nurse specialist available, who is involved in pressure injury management.</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 including (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.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The service employs a full time diversional therapist (DT) and part time recreational therapist (RT in DT training). The activity team attend Summerset training sessions and the regional DT group. Both activity persons have current first aid certificates.</p> <p>The integrated rest home and hospital programme covers seven days a week. The DT and RT are on together for two days of each week offering two choices of activities including outings on those days. 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 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 monthly entertainers and canine therapy.</p> <p>Residents are encouraged to maintain their former community links. Church services are held weekly. The service has a wheelchair van for the twice weekly outings for rest home and hospital residents.</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 DT is involved in the multidisciplinary review which includes the review of the activity plan.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<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 residents 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</p>

		completes three monthly reviews.
<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	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>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	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>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>	FA	<p>The building has a current building warrant of fitness that expires on 8 August 2016. There is a full time property manager who oversees the property and gardening team and is available on call for facility matters. The property manager is the national health and safety representative for Summerset and completes the required internal training as required. 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 August 2015. 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>The care centre is located on the first floor. Serviced apartment are on the ground floor. Corridors are wide</p>

		<p>in all areas to allow residents to pass each other safely. There is safe access to all communal areas and outdoor areas. There is an outdoor balcony with 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>	FA	<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 forty eight bedrooms have a hand basin. Forty four bedrooms have ensuites. The remaining four bedrooms are closely located to the communal toilet/shower rooms. There are adequate numbers of communal toilets located near the communal areas. 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>	FA	<p>There is adequate room to safely manoeuvre mobility aids and transferring equipment such as hoists in the resident bedrooms. The doors are wide enough for ambulance trolley access. Residents and families are encouraged to personalise their rooms as viewed on the day of audit.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Communal areas within the facility include a large main lounge that can accommodate rest home and hospital level residents and where most activities take place. There are two family rooms with tea making facilities. The spacious dining room has a separate conservatory which is used as an additional dining area. There are 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>	FA	<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. There are designated cleaning/laundry staff on duty each day. A chute is used to deliver dirty laundry from the care centre to the downstairs laundry. The laundry is well equipped and all machinery has been serviced regularly. There is a sluice area in the laundry with personal protective equipment available. The laundry has defined clean/dirty areas and an entry and exit door with adequate ventilation.</p> <p>Cleaning trolleys sighted were well equipped and are kept in designated locked cupboards when not in use. There are locked chemical boxes securely fixed to the top of the cleaning trolleys. 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 situations.</p>	FA	<p>There are emergency and civil defence plans 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 Bay has an approved fire evacuation plan and fire drills occur six monthly. Smoke alarms, sprinkler system and exit signs are in place. The service has alternative cooking facilities (three BBQ's) available in the event of a power failure. There are two civil defence kits in the facility and stored water. Call bells were evident in residents' rooms, lounge areas and toilets/bathrooms. The facility is secured at night.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>Visual inspection evidences that the residents have adequate natural light in the bedrooms and communal rooms. There is safe ventilation and an environment that is maintained at a safe and comfortable temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers,</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 (clinical nurse leader) 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 are reviewed and discussed at each infection control committee meeting.</p>

and visitors. This shall be appropriate to the size and scope of the service.		Visitors are asked not to visit if they are unwell. Influenza vaccines are offered to residents and staff. Hand sanitisers are available throughout the facility
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The infection control officer attended the two day annual Summerset training day for infection control officers in November 2015. The infection control officer also attended external training for pandemic planning (March 2015), infection control prevention (June 2015) and attends the DHB infection control meetings.</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>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>There are comprehensive infection control policies that are 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</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 handwashing 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</p>

providers, support staff, and consumers.		ensuring this occurs
<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>	FA	<p>The infection control policy includes a surveillance policy that includes 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 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 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>	FA	<p>There are policies around restraints and enablers. The service currently has four residents assessed as requiring the use of restraint (three bed rails and one lap belt) and one requiring enablers (bedrails only). The care plans are up to date and provide the basis of factual information in assessing the risks of safety and the need for restraint. On-going consultation with the resident and family/whānau is also identified. Residents voluntarily request and consent to enabler use.</p> <p>Staff receive training around restraint minimisation that includes annual competency assessments.</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>	FA	<p>A restraint approval process and a job description for the restraint coordinator are in place. The restraint coordinator role is delegated to the nurse manager. All staff are required to attend restraint minimisation training annually.</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>Only registered nursing staff can assess the need for restraint. Restraint assessments are based on information in the resident's care plan, discussions with the resident and family and observations by staff. A restraint assessment tool meets the requirements of the standard. Two hospital level residents' files where restraint was being used were selected for review. Each file included a restraint assessment and consent form that was signed by the resident's family. Restraint use is linked to the resident's care plan and is regularly reviewed.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>A restraint register is in place. The register identifies the residents that are using a restraint, and the type(s) of restraint used. The restraint assessment identified that restraint is being used only as a last resort. The restraint assessment and on-going evaluation of restraint use process includes reviewing the frequency of monitoring residents while on restraint. Monitoring forms are completed when the restraint is put on and when it is taken off.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>Restraint use is reviewed three monthly by the restraint committee during restraint meetings. The review process includes discussing whether continued use of restraint is indicated.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The restraint programme, including reviewing policies and procedures and staff education is evaluated annually by the national quality manager and the national education manager.</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.

No data to display

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
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>The service provides an environment that encourages good practice beyond the expected full attainment. The service has conducted quality improvement projects to support Somerset “do no harm” component as part of its commitment to improving resident care. A review process has occurred, including analysis and reporting of findings. There is evidence of action taken based on findings that has made improvements to service provision and resident care for (i) reduced weight loss and (ii) reduced skin tears.</p>	<p>(i) In September 2015, four residents were identified with weight loss. A project plan was implemented that included a range of initiatives including (but not limited to); a) providing an environment to promote and encourage appetite, b) maintaining safe staffing levels to provide assistance at meal times and c) provide and maintain adequate fluid and food intake. Where residents were identified with weight loss, a high energy/high calorie diet were provided, meals fortified, second portions offered, weekly weighs commenced and food and fluid charts maintained. The GP was notified and dietary supplements commenced. Resident dietary requirements were updated and the chef manager received a copy. Weights continue to be monitored monthly and MUST assessments completed monthly on the SWAY electronic data base. Dietitian referrals were evident. The data base evidences weight gain for those residents identified with weight loss. Residents with weight loss are offered protein shakes and coke floats (protein shakes) on alternate days. The number of residents with weight loss reduced to two residents for October and November and one resident in December 2015. Two resident files reviewed of residents with recent weight loss, demonstrated the action plan had been</p>

			implemented resulting in weight gain. .
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	CI	<p>Summerset in the Bay have implemented the comprehensive Summerset quality system. Monthly internal audits are undertaken as per schedule and audit action plans are completed as required depending on the result of the audit. The quality, RN and staff meetings document that key issues are discussed and action plans formulated Benchmarking reports are generated throughout the year to review performance over a 12-month period. Quality action forms are utilised at Summerset in the Bay and document actions that have improved outcomes or efficiencies in the facility. The service continues to collect data to support the implementation of corrective action plans. Responsibilities for corrective actions are identified.</p> <p>There is also a number of ongoing quality improvements identified through meeting minutes and as a result of analysis of quality data collected Summerset in the Bay is proactive in developing and implementing quality initiatives. All meetings include excellent feedback on quality data where opportunities for improvement are identified.</p>	<p>In May 2015, there were six bruising incidences reported residents. The service identified an improvement required around reducing the incidence of bruises. A project plan was implemented that included a range of initiatives including; a) manual handling training given by a physiotherapist, b) increased staff awareness of safe handling, c) increased communication at handovers and discussion around short term care plans and specific interventions for bruising, d) skin moisturizing for all residents with frail skin, e) vulnerable residents encouraged with fluids and commenced on hydration charts and f) arm and leg protectors purchased for added protection of limbs. The service has been successful in reducing the number of bruising incidents by 50% from 2.06 per 1000 bed days in May 2015 to 1.04 per 1000 bed days in January 2016. The bruising rate per month remains under the benchmarking level for the last seven months.</p>

End of the report.