# Summerset Care Limited - Summerset In The Sun

## Introduction

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

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

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

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

The specifics of this audit included:

**Legal entity:** Summerset Care Limited

**Premises audited:** Summerset In The Sun

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

**Dates of audit:** Start date: 21 September 2016 End date: 22 September 2016

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

**Total beds occupied across all premises included in the audit on the first day of the audit:** 47

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained  |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

## General overview of the audit

Summerset in the Sun provides rest home and hospital level care for up to 62 residents in the care centre (all dual-purpose beds) and rest home level care for up to 25 residents in the serviced apartments. On the day of audit, there were 38 residents in the care centre and 9 rest home residents in the serviced apartments.

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

There is an organisational risk management plan and a site-specific business plan 2016 – 2017. The quality and risk management plan is established. The service is managed by a village manager who is a registered nurse and has been at the facility since June 2016. She is supported by a relief nurse manager (who works for Summerset) who has been at Summerset in the Sun for three weeks. The regional quality manager (an experienced registered nurse) has been based at the facility since May 2016.

All of the seven shortfalls identified at the partial provisional audit conducted in March 2016 have been addressed. These were around employing staff for the proposed apartments for rest home level care, providing appropriately placed dining facilities for rest home residents in the proposed new apartments, assessments, care planning, wound management, evaluations, medication management and calibration of medical equipment.

In addition, the one outstanding shortfall from the previous surveillance audit conducted in August 2015 around signing and dating records has also been addressed.

This audit did not identify any areas requiring improvement.

## 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. |

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

## Organisational management

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

## 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 and in an ongoing manner. Assessments, care plans and evaluations are completed by the registered nurses. Risk assessment tools and monitoring forms are available. Short-term care plans are in use for changes in health status. There is a recreational therapist and a diversional therapist employed to implement the seven days per week activities programme. The activities provided are meaningful and reflect ordinary patterns of life. There are outings into the community, volunteer involvement and visiting entertainers. There are medication management policies that are comprehensive and direct staff in terms of their responsibilities in each stage of medication management. Medication profiles are electronic and meet legislative guidelines. Staff who administer medications have been assessed as competent to do so. Food services policies and procedures are appropriate to the service setting. The food service is provided by an external contractor. Resident's individual dietary needs are identified, documented and reviewed on a regular basis. Visual inspection of the kitchen shows evidence of compliance with current legislation and guidelines. Residents and family members interviewed were complimentary of the food service provided and report that individual preferences are well catered.

## Safe and appropriate environment

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

There is a current building WOF. Planned and reactive maintenance systems are in place. All equipment has been serviced and calibrated as required. Since the previous audit, dining areas have been created, near apartments on both floors in the area the service intends to eventually house rest home level residents.

## 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. |

There are documented policies and procedures around restraint use and use of enablers. There were three residents using restraint and two residents with enablers at the time of the audit. Staff training around the use of restraint and enablers is provided and staff interviewed understood the philosophy of minimal use.

## 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 and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Surveillance activities include audits of the facility, hand hygiene and surveillance of infection control events and infections. Staff receive ongoing training in infection control.

## Summary of attainment

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement****(CI)** | **Fully Attained****(FA)** | **Partially Attained Negligible Risk****(PA Negligible)** | **Partially Attained Low Risk****(PA Low)** | **Partially Attained Moderate Risk****(PA Moderate)** | **Partially Attained High Risk****(PA High)** | **Partially Attained Critical Risk****(PA Critical)** |
| **Standards** | 0 | 19 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 44 | 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

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

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | The service has a complaints policy that describes the management of the complaints process. Complaint forms are available in locations accessible to residents and family. Information about complaints is provided on entry in the admission pack. Interviews with residents and family members confirmed their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints.Any complaints received are entered into the Summerset way system (Sway) which also alerts head office. An electronic complaints register includes verbal and written complaints and evidence to confirm that complaints are being managed in a timely manner including acknowledgement, investigation, timelines, and corrective actions when required and resolutions. Five complaints received since May 2016 were managed within the required timeframes with evidence of comprehensive investigations undertaken by the village manager. The village manager informed the DHB about one complaint in an open disclosure manner. Outcomes from complaints have been used to develop quality improvement such as a form in each resident’s room documenting the date and time of the last daily, weekly and monthly clean for residents, family and staff to check and a communication book for cleaners. |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | An open disclosure policy describes ways that information is provided to residents and families. There is an admission pack that gives a comprehensive range of information regarding the scope of service provided to the resident and their family/whānau on entry to the service. The pack includes a copy of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). This information is discussed at entry and staff are available whenever the resident and family members wish to discuss any aspect of service delivery. Family are involved in the initial care planning, and receive and provide ongoing feedback. Two family members (one hospital and one rest home – serviced apartment) interviewed, stated they were well informed. Resident/family meetings are held three monthly. Ten incident/accident forms were reviewed and all identified that the next of kin were contacted. Residents (three rest home and two hospital) and family stated the service provides an environment that encourages open communication. Discussions with four caregivers, two registered nurses and the recreation therapist identified their knowledge around open disclosure. The service has policies and procedures available for access to interpreter services and residents (and family) are provided with this information in resident information packs.Residents and family members interviewed confirmed the admission process and agreement documentation were discussed with them. |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Summerset in the Sun provides rest home and hospital level care for up to 62 residents in the care centre (all dual-purpose beds) and rest home level care for up to 25 residents in the serviced apartments. On the day of audit, there was 25 rest home (including two respite residents and one on a long-term chronic condition contract) and 13 hospital residents in the care centre and nine rest home residents in the serviced apartments. There is a current risk management plan (critical and severe risks) and a business plan 2016 – 2017. The business plan for Summerset in the Sun includes business goals. The service is managed by a village manager, who is a registered nurse, with management qualifications and experience, and has been at the facility since June 2016. The previous nurse manager has resigned. Since this time, the regional quality manager has been at the facility, assisting to improve processes and documentation. She is an experienced aged care registered nurse. Three weeks prior to the audit a Summerset relief nurse manager took up post at the facility and will remain at Summerset in the Sun until a new nurse manager is appointed and a transition process has been completed. The regional quality manager will not be at the facility full time following the audit.The management team has maintained at least eight hours annually of professional development activities related to managing a hospital.  |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | A quality and risk management plan policy is in place that is reviewed annually. It is based on Summerset’s values and strategic plan. Policies and procedures reflect evidence of regular reviews as per the document control schedule. New and/or revised policies are made available for staff to read and sign that they have read and understand the changes. Policies and procedures have been updated to reflect the implemented InterRAI procedures. The monthly collating of quality and risk data includes (but is not limited to) residents’ falls, infection rates, and pressure areas. Data is collated and benchmarked against other Summerset facilities to identify trends. Any trends are addressed with corrective action plans and projects. Recent areas of focus that have resulted in improvements, including falls management and pain management.A resident satisfaction survey is conducted each year. An annual internal audit schedule confirmed audits are being completed as per the schedule. Corrective actions are developed where opportunities for improvements are identified and are signed off when completed. RNs are kept informed of quality and risk management activities, evidenced in the RN meeting minutes. Care staff meetings have begun to be held most weeks to improve communication and inform of processes/changes. Caregivers interviewed commented positively on improved communication and quality improvement systems. There is a quality improvement meeting held monthly. A falls reduction plan was sighted for the service. Sensor mats and physiotherapy services are utilised. Residents are checked regularly. A health and safety representative has been identified for the service. The service has introduced new policies to reflect changes in legislation. A new health and safety representative was recently appointed. Processes are in place for accident and incident reporting, injury prevention and management, workplace inspections and hazard management. The Summerset group has a ‘clinical audit, training and compliance’ calendar. The calendar schedules the training and audit (et al) requirements for the month and the village manager completes a ‘best practice’ sheet confirming completion of requirements. The best practice sheet includes reporting including (but not limited to), meetings held, induction/orientation, audits, competencies, projects. The best practice sheet is sent to head office as part of the ongoing monitoring programme. |
| Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.  | FA | The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. The reporting system is integrated into the quality and risk management programme. Once incidents and accidents are reported, the immediate actions taken are documented on incident forms. The incidents forms are then reviewed and investigated by the nurse manager. If risks are identified these are processed as hazards. Discussions with the village manager and nurse manager have confirmed their awareness of statutory requirements in relation to essential notification. A gastro outbreak in July 2016 was notified to Public Health and the DHB. The service collects incident and accident data and reports aggregated figures monthly to the integrated meeting. Incident forms are completed by staff, the resident is reviewed by the registered nurse at the time of event and the form is forwarded to the nurse manager for review and final sign off. Family are notified. Ten incident forms were reviewed and all had been completed appropriately and signed. This included incident forms for identified pressure injuries. |
| Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.  | FA | There are human resources policies to support recruitment practices. There are job descriptions available for all relevant positions that describe staff roles, responsibilities and accountabilities. A list of practising certificates is maintained. Seven staff files were reviewed (one recreation therapist, four registered nurses, one enrolled nurse and one caregiver); all had relevant documentation relating to employment. Evidence of signed employment contracts, job descriptions, orientation, and training were sighted. Performance appraisals had been completed in the three files sampled where the staff member had been employed longer than one year. 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. A competency programme is in place with different requirements according to work type (eg, caregiver, registered nurse, and kitchen). Core competencies are completed and a record of completion is maintained on staff files and well as being scanned into ‘Sway’. Staff interviewed were aware of the requirement to complete competency training. The service has provided a significant amount of staff in-service training in the past six months. The regional quality manager has worked alongside all registered nurses to improve skills around assessment, care planning and evaluation practices. She stated that rather than complete care plans, assessments and reviews, she has mentored the registered nurses to do this, to provide confidence that the improvements will be maintained. This was confirmed by the registered nurses.  |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. There are clear guidelines for increase in staffing depending on acuity of residents. Staffing has been increased since the previous audits. Staff have been employed to provide care for rest home residents in the newest apartments, meaning there is currently high numbers of staff. There are two caregivers on duty 24 hours per day in the serviced apartments to meet the needs of the nine current rest home residents. These staff have sufficient time to complete laundry and are based at a newly and appropriately positioned nurses’ station. These are improvements since the previous audit. Registered nursing has been increased and there are now two registered nurses (in addition to management) on day shift, a registered nurse and an enrolled nurse on evening shift and one registered nurse on duty overnight. The roster considers the building design and a further nurses’ station has been be placed in the foyer area of the new upstairs wing. There are separate cleaning staff. |
| Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | Care plans and notes are legible. All resident records contain the name of resident. In files sampled, entries were legible, dated and signed by the relevant caregiver or registered nurse. This is an improvement since the previous audit. Policies contain service name. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public.  |
| Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | The service medication policies and procedures follows recognised standards and guidelines for safe medicine management practice in accordance with the Medicines Care Guide for Residential Aged Care 2011. There is one locked medication room for the upstairs hospital/rest home and rest home residents in the serviced apartments. The facility uses two weekly supplied robotic sachets for regular and ‘as required’ medication delivered by the supplying pharmacy. Medications are checked against the signing sheets on arrival at the facility. Any discrepancies are fed back to the pharmacy. There is a small stock of medications, primarily for end of life care. A process has been developed where all stock medications, including those in the fridge have the expiry date documented on a form, which is checked weekly by a night shift registered nurse. There were no expired medications and this previous shortfall has been addressed. An electronic medication documentation system is used and review of reports and 10 medication records demonstrated that best practice for medication prescribing and documentation is implemented including indications for use documented for all ‘as required’ medications. The previous shortfall has been addressed. All medications are kept in a locked trolley in the treatment room. The medication fridge temperature is recorded daily. A stock of hospital medications is kept in the medication room. Locked drawers are available for those that choose to self-medicate. There were no residents self-administering/self-medicating.All RNs that administer medication are competent and have received medication management training. Senior caregivers co-sign for controlled drugs only, and have received medication management training and have current competencies.Ten resident medication charts sampled included photographs and allergy status. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | There is a large kitchen and external contractors cook all food on site. There is a comprehensive kitchen manual in place. There is a qualified chef on duty that is currently covering seven days per week while a second cook is recruited. They are supported by a morning and afternoon catering assistant. There is an eight-week seasonal menu in place. The menu is reviewed annually. The chef receives a dietary profile for each resident with dietary requirements, special diets, food allergies, likes and dislikes. Alternatives are offered. The chef is notified of any dietary changes for the residents. Food is transported in hotboxes to the dining room where it is served from a bain-marie. The upstairs dining area has a kitchenette. Special diets are plated and labelled. The fridge and freezer have visual temperatures, which are recorded daily. The facility fridges temperatures are monitored (records sighted). Temperature of food on delivery is recorded. Feedback on the service and meals is by direct verbal feedback and residents’ meetings. There is a downstairs dining area for rest home residents in serviced apartments.Staff working in the kitchen have food handling certificates and receive ongoing training. |
| Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | The previous audit identified that pain monitoring had not consistently occurred, InterRAI contractual requirements had not been met and risk assessments had not been reviewed six monthly. All five files sampled for this audit had clinical risk assessments including continence, safe handling, falls risk, pressure area risk, mini nutritional assessment, culture assessment, and pain assessments completed on admission. Challenging behaviour and wound assessments are completed as required. The four long-term files had InterRAI assessments completed and all were current. Two of the four, admitted in mid-2015 did not have InterRAI assessments completed on admission and two had risk assessments reviewed in early 2016 but InterRAI was not used. As the service had trained staff and improved systems since May/June 2016 the sample was extended to include six further long-term residents admitted since this time. All six had InterRAI assessments completed within three weeks of admission, indicating the issue has been addressed. Four residents’ medication records sampled with ongoing and intermittent pain had ongoing pain monitoring and behaviour monitoring was occurring for residents with behaviours that challenge. One resident file sampled had an InterRAI assessment completed following a significant change in health status. The previous shortfalls have been addressed.  |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | In all five care plans reviewed, care plans included all interventions to support current needs (four long-term care plans and one short stay care plan). This is an improvement since the previous audit. Residents interviewed stated their needs are being met. Relatives interviewed stated their relatives receive care within a timely manner and they are kept informed of any health changes, GP visits and care plan reviews. All described improvements in recent months.Dressing supplies are available and a treatment room is stocked for use. Continence products are available and resident files include continence management. Specialist continence advice is available as needed and this could be described. Continence management in-services and wound management in-service have been provided. Wound assessment and ongoing assessment and treatment plans are in place for six residents with eight wounds. Those reviewed included four skin tears, one bruise/wound, one necrotic wound and two grade-3 pressure injuries (for one resident). The pressure injuries had been referred for wound nurse specialist input and one other wound had been reviewed by the wound nurse specialist. All wounds had been reviewed in appropriate timeframes. This is an improvement since the previous audit. Residents’ weights are recorded on admission and monthly thereafter, on the monthly weight chart. Where a risk is identified, care plans identified increase monitoring of weight and implementation of food/fluid charts. There were consistent records kept around weight documentation. |
| Standard 1.3.7: Planned ActivitiesWhere specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | Five files reviewed included activity plans. Monthly progress notes are written. There is evidence of an implemented activities programme in all areas. The diversional therapist provides activities five days a week and a recreational therapist three days a week (there is a one-day overlap to allow two staff to facilitate outings for hospital level residents). Activities are planned that are appropriate to the functional capabilities of residents, taking into consideration physical and cognitive abilities and sensory impairment. One-on-one time is spent with hospital level residents or those who choose not to participate in the groups and includes reading/chats and pamper sessions. Residents go out to regular community events. Special events, festive occasions and birthdays are celebrated. There are twice monthly church services on a rotation basis for the churches. Kindergarten and intermediate school children visit. There are twice weekly van outings and residents provide feedback and suggestions for the outings. There is a knitting circle, scrabble group and floral group. Residents in the serviced apartments who are receiving rest home level care can choose to attend either the village programme or the care centre programme. There is increasing integration between the village and the care centre and village residents volunteer and assist with activities. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | There was evidence in files sampled of resident and family (where appropriate) involvement in MDT reviews. Three long-term care plans reviewed that had been with the service longer than six monthly had at least six monthly documented evaluations. Areas of identified risk had been evaluated at least monthly and in some cases weekly. There were short-term care plans to focus on acute and short-term issues. These are reviewed daily by a registered nurse and an evaluation documented daily. The previous shortfall has been addressed.  |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | There is a current building WOF that is prominently displayed. Planned and reactive maintenance systems are in place and maintenance requests are generated through the on-line Sway programme. There is a lift between the ground floor (care apartments) and the first floor (care centre). The maintenance person for Summerset in the Sun care centre and village is employed full-time and is available on call. A monthly maintenance schedule is generated on-line from head office and the maintenance person provides a monthly report. Hot water temperatures are recorded monthly and are consistently reading 42-45 degrees Celsius. Preferred contractors are available 24/7. There is adequate and safe storage of medical equipment, which was calibrated between May and July 2016. This is an improvement since the previous audit. Corridors are wide enough in all areas to allow residents to pass each other safely with safe access to communal areas and outdoor areas. There is outdoor seating and shade and all areas are landscaped. There is a designated smoking area off the upstairs deck.  |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And DiningConsumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | The newest apartments have not been approved for use by rest home level residents. At the request of the DHB, dining facilities for these apartments were reviewed following an identified shortfall at the partial provisional audit. A dining area to cater for up to eight residents, and within walking easy walking distance for rest home level residents in the closest eight apartments, has been developed on each floor. There are sufficient dining and large lounge areas to cater for all residents.  |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Infection monitoring is the responsibility of the infection control coordinator. The infection control policy describes routine monthly infection surveillance and reporting. Responsibilities and assignments are described and documented. The surveillance activities at Summerset in the Sun are appropriate to the acuity, risk and needs of the residents. The infection control coordinator enters infections on to the infection register and into the ‘sway’ database, which generates a monthly analysis of the data. The analysis is reported to the monthly quality meetings (minutes viewed).  |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. The policy includes comprehensive restraint procedures. A registered nurse is the restraint coordinator with a job description that defines the role and responsibilities. The policy identifies that restraint is used as a last resort. The service currently has two hospital residents with enablers and three hospital residents using restraint. There is provision for emergency restraint and the nurse manager is contacted for prior approval, for restraint to be implemented. There is a restraint committee (restraint coordinator, nurse manager and caregiver) that meet three monthly and report to the quality committee. Enablers are voluntary and the least restrictive option. The resident and family have been provided with information on use of enablers; a consent form has been signed. Use of enabler and risks were documented in the long-term care plan of the three enabler files reviewed.  |

# Specific results for criterion where corrective actions are required

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

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

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

|  |
| --- |
| 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.

|  |
| --- |
| No data to display |

End of the report.