

Summerset Care Limited - Summerset on Summerhill

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Summerset Care Limited
Premises audited:	Summerset on Summerhill
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 29 November 2016 End date: 30 November 2016
Proposed changes to current services (if any):	Two sun lounges were verified at this audit as suitable for rest home or hospital level of care. The total number of dual purpose beds will increase from 43 to 45.

Total beds occupied across all premises included in the audit on the first day of the audit: 44

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Summerset on Summerhill provides rest home and hospital (geriatric and medical) level care for up to 43 residents in the care centre. Two sun lounges were also verified as part of this audit as suitable as resident rooms for rest home/hospital level of care; increasing the numbers of beds to 45. On the day of audit there were 44 residents.

The service is managed by a non-clinical village manager who has experience in business management and human resources. The nurse manager has clinical management experience in aged care. The management team are supported by operational and clinical managers at head office. The residents and relatives interviewed spoke positively about the care and services provided.

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

The service has addressed three of four previous certification findings around progress notes, care plans and aspects of medicine management.

An improvement continues to be required around interventions.

The service has maintained a continuous improvement around surveillance of infections.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Residents and relatives interviewed report that they are kept informed on all changes to health. Regular resident's meetings are held. Residents and their family/whānau are provided with information on the complaints process on admission. Staff are aware of the complaints process and to whom they should direct concerns or complaints. Complaints processes are being implemented, managed and documented.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Services are planned and are appropriate to the needs of the residents. A village manager and nurse manager are responsible for the day-to-day operations of the facility. Quality and risk management processes have been established including: a site-specific quality plan and goals, risk management programme, incident and accident reporting, infection control data, internal audits, surveys, quality and service meetings and health and safety processes.

Residents receive services from qualified staff. Human resources are managed in accordance with good employment practice. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an ongoing in-service training programme covering relevant aspects of care. Registered nursing cover is provided 24 hours a day, 7 days a week. There are adequate numbers of staff on duty to ensure resident safety.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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The registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with resident and/or family/whānau input. Care plans viewed in resident records demonstrated service integration and are evaluated at least six-monthly. Resident files included medical notes by the GPs and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and caregivers responsible for administration of medicines complete education and medication competencies. The medicine charts reviewed meet prescribing requirements and were reviewed at least three-monthly.

Two recreational therapists are responsible for providing a seven-day week activity programme for residents. The programme includes community visitors and outings, entertainment and activities that meet the individual recreation, physical, cultural and cognitive abilities and preferences for each resident group.

Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on-site. Food, fluid and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirement/modified needs were being met.

Safe and appropriate environment

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

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Staff receive training around restraint minimisation, the management of challenging behaviour and complete restraint competencies. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraints and enablers. On the day of audit, the service had eight residents who voluntarily requested enablers and eight residents on restraint.

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 coordinator (RN) is responsible for coordinating and providing education and training for staff. The infection control surveillance programme is appropriate to the size and complexity of the service. Results of surveillance are acted upon, evaluated and used to determine infection control activities, resources and education needs within the facility. 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	0	20	0	1	0	0	0
Criteria	1	44	0	1	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy states the village manager has overall responsible for ensuring all complaints (verbal or written) are fully documented and investigated. There is an online complaints register that includes all complaints including complaints from the village. There have been two care centre complaints received by the DHB and investigated by Summerset head office. Documentation viewed on-site evidenced the complaints had been resolved. The complaints (not care related) had been entered into the online register.</p> <p>Concerns and complaints are discussed at management and clinical meetings. A complaints procedure is provided to residents within the information pack at entry. Feedback forms are available for residents/relatives in the main entrance of the facility.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an</p>	FA	<p>Residents (one hospital and four rest home) and relatives (two hospital residents) stated they were welcomed on entry and were given time and explanation about services and procedures. The relatives stated they were kept informed of changes in the resident's health status and any incidents/accidents. Resident meetings are held three-monthly. The village manager and nurse manager have an open-door policy.</p> <p>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).</p>

environment conducive to effective communication.		
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The service currently provides care for up to 43 residents at hospital and rest home level care in the care centre. Two sun lounges were assessed as suitable for dual purpose rooms. On the day of audit, there were 44 residents which included eight rest home residents (including one resident on a radiology contract and one respite care) and 36 hospital residents (including three younger persons and two residents on the intermediate healthcare recovery contract) in the care centre. All 43 beds in the care centre are dual purpose. There is a retirement village attached as part of the complex with overall management of the site provided by a village manager.</p> <p>The Summerset Group Limited Board of Directors have overall financial and governance responsibility and there is a company strategic business plan in place. Summerset on Summerhill has a site-specific business plan and goals for 2016 which are reviewed three-monthly with the management team. Ongoing goals relate to health and safety, falls reduction and the inclusion of recreational activities for residents with dementia.</p> <p>The village manager (non-clinical) has been in the role three years. The nurse manager/registered nurse (RN) has been in the role three and a half years and supported by a team of RNs and stable workforce. A senior RN has been appointed into the clinical nurse leader role and will commence orientation in the near future. The village manager has completed at least eight hours of education annually including attending the two-day Summerset forums for managers, Summerset regional meetings, ARCC meetings and dementia care training.</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>Quality and risk management policies, processes and systems are directed from head office and implemented and monitored by the village manager and nurse manager. Policies and procedures reflect evidence of regular reviews. Policies reflect the implementation of the interRAI assessment and changes in pressure injury prevention and management as per the MOH guidelines. New and/or revised policies are made available for staff to read and sign that they have read and understand the changes. Four caregivers interviewed confirmed they sign the reading form for new/reviewed policies and meeting minutes.</p> <p>The monthly collating of quality and risk data includes (but is not limited to): residents' falls (with and without injury), bruises, challenging behaviours, infection rates, skin tears and pressure injury. Data is collated monthly on the SWAY (Summerset way) data base and benchmarked against other Summerset facilities to identify trends. Quality alerts are received from head office for any unwanted trends identified within facilities. Quality improvement plans/actions (QIP) have been developed for areas of improvement and progress evaluated at management meetings. An example of one QIP is reduction of falls with residents encouraged to attend exercises, analysing the time of day of falls and adjusting the staff working times to provide more supervision at these times. Resident-centred care plans (RCCP) document appropriate interventions for falls prevention. The DHB target for vitamin D administration is 70% and in September 2015 Summerhill had achieved 75% residents on vitamin D. Other QIPs in</p>

		<p>place include the pressure injury prevention plan and end of life action plan which includes implementation of advance directives and ongoing staff training.</p> <p>There are a number of facility meetings including quality improvement, management, infection control, health and safety, restraint and clinical meetings (RNs and caregivers). Meeting minutes distributed to staff evidence discussion around quality data, trends/analysis, internal audit outcomes and corrective actions.</p> <p>A resident satisfaction survey is conducted each year. Results for October 2015 were analysed with an overall result of 94%. Results were collated and feedback to residents. The October 2016 survey is in the process of being collated.</p> <p>An annual internal audit schedule was sighted with audits completed as per the schedule. Audits include clinical, environmental, infection control and service audits. A corrective action plan is raised for non-compliance with re-audits as required. Meeting minutes' evidence discussion around outcomes of internal audits.</p> <p>The health and safety programme is overseen by a health and safety officer who is the property manager. The health and safety committee meet three-monthly and includes representatives nominated from each area of work. Staff have the opportunity to have any health and safety concerns addressed at the meeting and the outcomes are fed back to the staff. The health and safety representative interviewed has been in the role nine months and has confirmed the committee has received an update on the health and safety legislation. All contractors involved in the service met in May 2016 for an update to the new legislation. A contractor's board to monitor hazards is used daily as required. Hazard identification forms are available and a current hazard register is in place.</p> <p>Falls prevention strategies are in place that include the identification of interventions on a case-by-case basis to minimise future falls. A physiotherapist is available by referral for resident concerns, mobility assessments and provide staff training for safe manual handling and hoist use.</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</p>	<p>FA</p>	<p>Incident and accident data has been collected, analysed and entered into the SWAY data base (sighted). Twelve resident related incident reports for November 2016 were reviewed. Incident forms identified timely RN assessment, corrective action and follow up. Neurological observations had been completed for unwitnessed falls. Corresponding progress notes reviewed documented incidents and interventions. Care plans reviewed included appropriate falls prevention interventions.</p> <p>Discussions with the service confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been two section 31 notifications in 2016 (one fracture requiring hospitalisation and a flooding incident requiring the evacuation of residents in the eight-bed wing). An improvement in emergency planning was identified and meetings have been held with the local community and DHB to develop the emergency plan around civil defence and evacuation procedures for the facility. The health and safety consultants from head office were involved in a debrief for staff and corrective actions. Water valves have been</p>

their family/whānau of choice in an open manner.		replaced in the ceiling to isolate the water supply to the three wings.
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	<p>There are job descriptions available for all relevant positions that describe staff roles, responsibilities and accountabilities. The practising certificates of nurses and allied health professionals are current. Six staff files were reviewed (two RNs and four caregivers). Evidence of signed employment contracts, job descriptions, orientation and staff training were available in staff files. Annual performance appraisals for staff are conducted annually. Newly appointed staff complete an orientation that is specific to their job duties. Interviews with four caregivers could describe the orientation programme that includes a period of supervision with a “buddy”.</p> <p>The service has a training policy and schedule for in-service education which aligns with policy reviews and internal audit programme. The in-service schedule is implemented and attendance is recorded. Staff complete competencies relevant to their role. The nurse manager and diversional therapist are qualified workplace assessors. Care staff have the opportunity to complete Careerforce qualifications. Eleven caregivers have completed Careerforce qualifications this year (six level 4 and five level 3). Two cleaners have completed level 2. There is a staff member on duty at all times with a current first aid certificate.</p>
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	<p>The village manager and nurse manager work 40 hours per week Monday to Friday and are available on call for any emergency issues or clinical support. The service provides 24-hour RN cover. There are three RNs on morning shift with two on the afternoon shifts and one on night shift. There are adequate numbers of caregivers on each duty. Clinical staff interviewed confirmed that staff are replaced and there are sufficient staff on duty. Staffing levels and skills mix policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery. There are dedicated activity and housekeeping staff.</p>
Standard 1.2.9: Consumer Information Management Systems Consumer information is	FA	<p>Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. Care plans and notes were legible and signed and dated by a registered nurse. Entries into progress notes are legible, dated, timed and signed by the relevant care assistant or registered nurse including designation. The previous finding around time of entry in progress notes has been addressed.</p>

<p>uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>		
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements and guidelines. Clinical staff who administer medications (RNs and senior caregivers) have been assessed for competency. Education around safe medication administration and the use of the electronic medication system has been provided. Medication blister packs are used for regular and prn medications. There were no residents self-medicating on the day of audit. All 10 medication charts sampled met legislative prescribing requirements and the GPs had reviewed the medication charts three-monthly. There are no standing orders in use. All medications are stored safely. Eye drops in use had been dated on opening. The medication fridge and medication room temperatures is monitored weekly and are maintained within acceptable ranges.</p> <p>Ten medication charts (including short-stay residents) were reviewed on the electronic medication system. All charts had photo identification and allergy status. There was documented evidence of medication reconciliation. All signing sheets corresponded with the medication chart. Medication administration monitoring includes weekly checks and monthly audits. The previous findings around transcribing, standing orders, medication reconciliation and medication prescribing have been addressed.</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>	<p>FA</p>	<p>All meals at Summerset on Summerhill are prepared and cooked on-site by a qualified chef and kitchen staff. There is an eight-weekly seasonal menu which has been reviewed by a dietitian. Dietary needs are known with individual likes and dislikes accommodated. Dietary requirements, cultural and religious food preferences are met and additional or modified foods are provided when needed. Staff were observed assisting residents with their meals and drinks in the dining rooms. The chef is notified if there are any changes to resident's dietary needs or weight loss. Meals are served from a bain marie.</p> <p>Temperatures are monitored daily for the fridges, freezer and end cooked foods. All foods were stored correctly and dated. Cleaning schedule is maintained.</p> <p>Feedback on the meals and food service generally, is provided by one to one comment, resident meeting minutes and surveys. Residents and family members interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes.</p> <p>Food services staff have completed training in food safety and hygiene.</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Resident-centred care plans describe the individual support and interventions required to meet the resident goals. The care plans for long-term residents (including the younger person) overall reflected the outcomes of risk assessment tools (link 1.3.6.1). The previous finding around care plan interventions has been addressed.</p> <p>Short-term care plans were in use for changes in health status. These have been evaluated regularly and either resolved or if an ongoing problem added to the long-term care plan.</p> <p>An initial assessment and support plan has been completed for short-term residents (respite, radiation services and intermediate care contract).</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Low</p>	<p>When a resident's condition alters, the registered nurse initiates a review and if required, GP and relevant allied health input is sought. There is evidence that family members are notified of any changes to their relative's health including (but not limited to): accidents/incidents, infections, health professional visits and changes in medications. Discussions with families and notifications are documented in the resident file.</p> <p>Adequate dressing supplies were sighted. Wound management policies and procedures are in place. Wound assessments and treatment plans and evaluations were in place for all current wounds. Chronic wounds are linked to the long-term RCCP. There was one facility-acquired stage I (heel) pressure injury on the day of audit. Wound nurse specialist is available as required. Continence products are available and residents' files include a continence assessment and continence products to use.</p> <p>Residents are weighed monthly or more frequently if weight is of concern. Nutritional requirements and assessments are completed on admission identifying resident nutritional status and preferences. All residents with wounds are commenced on high protein drinks. Monitoring occurs for weight, vital signs, blood glucose and food/fluid intake. Pain status was not reflected in the care plan for two residents who identified pain. The previous finding around documented interventions remains.</p> <p>Short-term care plans document appropriate interventions to manage short term changes in health.</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</p>	<p>FA</p>	<p>The service employs a registered diversional therapist (25 hours per week) and one recreational therapist in training (20 hours per week) to coordinate and implement the seven-day week activity programme. The activity programme is integrated and meets the needs of the rest home and hospital residents. The monthly programme includes a variety of activities such as exercises, music, word games, short stories, gardening, art, painting and floral art. Theme days are held and events celebrated. Community involvement includes church services, pre-school children visits, international school students, kapa haka groups, Scottish society and entertainers. The activity team have introduced a lady's coffee club, men's time and cognitive stimulation group (a smaller activity group for residents with memory loss). There are weekly outings for rest home and hospital residents to places of interest.</p>

needs, age, culture, and the setting of the service.		<p>An activity assessment is completed on admission in consultation with the resident/family (as appropriate). Each resident has diversional therapy care plan that is reviewed at least six-monthly.</p> <p>The residents have the opportunity to provide feedback and suggestions on the programme through two-monthly resident meetings and surveys.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Initial care plans are evaluated within three weeks. Long-term care plans have been reviewed at least six-monthly or earlier for any health changes. The GP reviews the residents at least three-monthly or earlier if required. Ongoing nursing evaluations are documented and are evident in changes made to care plans for residents under all contracts.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building has a current building warrant of fitness that expires on 24 July 2017.</p> <p>Two sunrooms were verified as suitable for conversion to dual purpose bedrooms. Each sunroom is located at the end of a wing of bedrooms. The room is spacious enough for residents to mobilise safely and for the use of a hoist if required. The bedroom is closely located to a shower/toilet room within the wing. There are other lounges available for residents.</p> <p>One wing of eight bedrooms and sun lounge has been fully refurbished following a flood. There is an ongoing replacement plan for bedroom flooring. Carpet is being replaced by non-slip vinyl in bedrooms. The concrete floors are being sealed as part of the flooring replacement programme.</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,</p>	FA	<p>Two sun lounges have been assessed as suitable for bedrooms. Remaining communal areas include a main lounge, family room with tea making facilities and a sunroom at the end of the third wing of bedrooms. There is adequate seating available in the dining room to accommodate the residents.</p>

activity, and dining needs.		
<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>The sunrooms assessed as suitable for bedrooms have a fire exit door within the room. The entry door to the sunrooms are fire doors. The fire service provider viewed the sun lounges and approved the rooms for use as bedrooms (letter sighted). Both sun lounges have call bells appropriately placed.</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>There is adequate ventilation and light in the two sun lounges to be converted as bedrooms. The windows across the external wall have been tinted for privacy with curtains for added privacy. There is underfloor heating in place.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified</p>	FA	<p>The infection control policy includes a surveillance policy including a surveillance procedure, process for detection of infection, infections under surveillance, outbreaks and quality and risk management. Infection events are collected monthly and entered onto the SWAY electronic system. The infection control officer (senior RN) provides a monthly infection control report of data, trends and relevant information to the quality improvement team. Infection control data is discussed at clinical meetings and information is available to all staff. The facility is benchmarked against other Somerset facilities of similar size. There have been no outbreaks.</p>

in the infection control programme.		
<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 eight residents who have voluntarily requested the use of an enabler. Four of eight files reviewed evidenced enabler assessments and current care plans that identified the use of the enabler, risks associated with enabler use and monitoring requirements. The use of enablers is reviewed six-monthly in conjunction with the care plan review. The restraint officer is the nurse manager. Staff receive training around restraint minimisation that includes restraint competency assessments. There were eight residents with restraints.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Low	Pain assessments (either interRAI or paper based) had been completed for four of six residents where pain had been identified. The outcomes of pain assessments had been documented in the care plan for four of six residents (three long term and one short term).	(i)The pain management plan in one hospital resident file does not reflect the type and location of pain as identified in the interRAI assessment (pain score 4), and (ii) The pain assessment is incomplete for one intermediate care resident who identifies pain. Pain management has not been identified in the initial care and support plan.	<p>Ensure pain status and management is documented in the care plan.</p> <p>90 days</p>

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 3.5.7</p> <p>Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>	CI	<p>The surveillance results are analysed for trends.</p> <p>Action plans are developed where infections have increased.</p>	<p>An action plan was developed for an increase in urinary tract infections (UTI) of nine in June 2016. Hydration and hygiene for individual residents was monitored with an increase in staff awareness through discussion, education and hand hygiene competencies. Housekeeping staff were included in the quality improvement project. The cleaning product was changed to a chlorwhite product. Cleaning schedules have been changed to twice daily for all toilets. The number of UTIs have gradually reduced to one in November 2016. The data has been analysed and evaluated monthly with a formal evaluation due in December 2016. The service has maintained a continuous improvement rating for surveillance.</p>

End of the report.