

Summerset Care Limited - Summerset Falls

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 Falls
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 5 December 2016 End date: 6 December 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:	45

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 Falls provides rest home and hospital (geriatric and medical) level care for up to 41 residents in the care centre and up to 44 rest home level of care residents in serviced apartments. On the day of the audit there were 45 residents. 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 an acting nurse manager (registered nurse) who oversees the clinical services. There are quality systems and processes being implemented. An induction and in-service training programme is in place to provide staff with appropriate knowledge and skills to deliver care.

This certification audit identified improvements around InterRAI assessments and interventions.

The service has been awarded a continuous improvement for the reduction of respiratory infections.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Summerset Falls provides care in a way that focuses on the individual resident. 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.
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Summerset Falls has an established 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

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The service has a well-developed information pack available for residents and families/whānau at entry. Initial assessments, resident centred care plans and evaluations were completed by the registered nurses within the required timeframes. Risk assessment tools and monitoring forms were available and implemented. Resident centred care plans were individualised and reflected the resident's needs and supports.

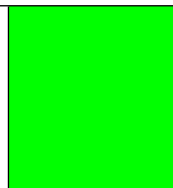
A recreational therapist coordinates and implements an integrated activity programme. The activities meet the individual recreational needs and preferences of the residents. There are outings into the community and visiting entertainers.

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.

All meals are prepared on-site. Resident's individual dietary needs are identified and accommodated. Staff have attended food safety and hygiene training.

Safe and appropriate environment

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



Standards applicable to this service fully attained.

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 the rooms without ensuites are 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 and six monthly fire drills are conducted. Housekeeping staff maintain a clean and tidy environment. All laundry and linen is completed on-site. There is plenty of natural light in all rooms and the environment 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.

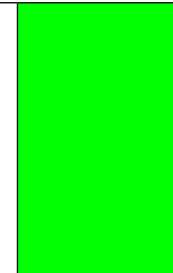


Standards applicable to this service fully attained.

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. Staff receive regular education and training on restraint minimisation. On the day of audit there were no residents using enablers and one resident with a restraint in place.

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 (registered nurse) 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	0	48	0	1	1	0	0
Criteria	1	98	0	1	1	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 seven caregivers, one registered nurse (RN), and one recreational therapist confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Eleven residents (six rest home and five hospital) and five relatives (three rest home and two hospital) were interviewed and confirmed the services being provided are in line with the Code. Observation during the audit confirmed this in practice.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. Seven resident files (four hospital and three rest home level of care including one respite care and one resident in the serviced apartments) evidenced written general and specific consents. 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/enduring power of attorney (EPOA) where the resident was deemed incompetent to make a decision.</p> <p>Discussion with family members (two hospital and three rest home) identified that the service actively involves them in decisions that affect their relative's lives. Six admission agreements for long-term</p>

		residents were sighted and signed. The respite care resident had signed an admission agreement.
<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 responsibility for ensuring all complaints (verbal or written) are fully documented and investigated. There is a complaint register that included relevant information regarding the complaint. The number of complaints received each month is reported monthly to staff via the various meetings. There have been six complaints received since the last audit in March 2016. All of the complaints documentation included follow-up letters, investigations and resolutions that had been completed within the required timeframes. Corrective actions have been implemented and any changes required were made as a result of the complaint. 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 were 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. 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 2016.</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. At the time of the audit there were no residents that identified as Māori. Links are established with local Iwi, Ngati Manuhuri at Omaha Marae. 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.</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 family/whānau 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 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 and nurse manager confirmed an awareness of professional boundaries.</p>

<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Residents and relatives interviewed spoke positively about the care and support provided. Staff have a sound understanding of principles of aged care and state that they feel supported by the village manager and nurse manager. All Summerset facilities have a master copy of policies which have been developed in line with current accepted best practice and are reviewed regularly. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff. There is a quality improvement programme that includes performance monitoring against clinical indicators and benchmarking against like services within the group is undertaken. There is 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 caregivers and registered nurses including (but not limited to): insulin administration, medication, wound care and manual handling.</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 meetings are held monthly and relative meeting every three months. An advocate from Age Concern attends the meetings. 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 41 residents at hospital and rest home level care. There are also 44 certified rest home beds in the serviced apartments. On the day of the audit, there were 45 residents in total, 17 residents at rest home level including one respite care resident, 23 residents at hospital level and five residents at rest home level of care in serviced apartments. All beds in the care centre are dual-purpose beds. There were no residents under the medical component of the certification. All long-term residents were under the ARC contract.</p> <p>Summerset Falls has a site-specific business plan and goals that is developed in consultation with the village manager, nurse manager and regional operations manager. The Summerset Falls quality plan is reviewed regularly throughout the year. There is a full evaluation at the end of the year.</p> <p>The village manager has been in the current role since April 2016 and has been at Summerset Falls for three years. The village manager is supported by the Summerset regional clinical manager and a nurse manager. The nurse manager has been in the position for four months and has a background in aged care nursing. At the time of the audit the nurse manager was away on leave until the end of January</p>

		<p>2017. The clinical nurse leader had been seconded into the acting nurse manager role. A RN had also been seconded to an acting clinical nurse leader role. There is a regional operations manager who is available to support the facility and staff.</p> <p>Village managers and nurse managers attend two day organisational forums annually. 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 Somerset 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>Somerset Falls 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 Somerset 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 (eg, incident trends, infection rates). Registered nurse meetings are held monthly. Health and safety, infection control and restraint meetings occur four monthly. There are other facility meetings held, such as kitchen and activities. An annual residents/relatives survey completed (October 2015) reports overall 95% feedback of experience being good or very good. The results for the residents/relative's survey completed in October 2016 had not been released at the time of the audit.</p> <p>The service is implementing an internal audit programme that includes aspects of clinical care. Issues</p>

		<p>arising from internal audits are developed into corrective action plans. Monthly and annual analysis of results is completed and provided across the organisation. Health and safety internal audits are completed. 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. Summerset's clinical and quality manager analyses data collected via the monthly reports and corrective actions are required based on benchmarking outcomes. There is a health and safety and risk management programme in place including policies to guide practice. One of the caregivers 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 November 2016 were reviewed (eight falls, two skin tears, one bruise and one challenging behaviour). 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. A section 31 incident notification form was completed (sighted) for a stage-three pressure injury that was non-facility acquired in August 2016.</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 leader, one recreational therapist, one housekeeper 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).</p> <p>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'. 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. Caregivers complete an aged care programme.</p>

<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The village manager and nurse manager work 40 hours per week (Monday to Friday) and are available on call for any emergency issues or clinical support. The service provides 24-hour RN availability. There are seven caregivers on morning shifts, four on the afternoon shifts and two on night shifts. In the serviced apartments, there are two caregivers on morning shifts, one on the afternoon shift and one on night shift. A staff availability list ensures that staff sickness and vacant shifts are covered. Caregivers interviewed confirmed that staff are replaced. Staffing levels and skills mix policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The resident files were appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access by being held in a locked cupboard. Care plans and notes were legible and where necessary signed (and dated) by a registered nurse. Entries are legible, dated and signed by the relevant care assistant or registered nurse including designation. Individual resident files demonstrate service integration. There is an allied health section that contained general practitioner notes and the notes of allied health professionals and specialists involved in the care of the resident.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>All residents have a needs assessment completed prior to entry that identifies the level of care required. The nurse manager screens all potential enquiries to ensure the service can meet the required level of care and specific needs of the resident.</p> <p>Residents (six rest home including two serviced apartments and five 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 transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>There is an exit discharge and transfer policy that describes guidelines for death, discharge, transfer, documentation and follow-up. All relevant information is documented and communicated to the receiving health provider or service. Follow-up occurs to check that the resident is settled or, in the case of death, communication with the family is made.</p>

<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>There are medicine management policies and procedures that align with recognised standards and guidelines for safe medicine management practice. Registered nurses are responsible for the administration of medications in the care centre. Medication competent caregivers administer medications in the serviced apartments.</p> <p>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 September 2015. Standing orders are not used. There were no residents self-medicating on the day of audit.</p> <p>Thirteen resident medication charts on the electronic medication system and one paper-based medication chart (respite care resident) were reviewed. All medication charts had photograph identification and allergy status recorded. Staff records the time, date and effectiveness of 'as required' medications. The nurse manager monitors for missed medications weekly. All 13 medication charts reviewed on the electronic medication system 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>	<p>FA</p>	<p>All meals are prepared and cooked on-site. There is an eight-week rotating seasonal menu approved by the dietitian. The menu includes resident preferences. The chef manager (interviewed) receives a dietary profile for each resident and 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 care centre satellite 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, vegetarian and gluten free meals are provided.</p> <p>The fridge and freezer have daily temperatures recorded. End cooked food temperatures are taken and recorded daily. All foods are stored correctly and date labelled. Cleaning schedules are maintained. Staff were observed wearing correct personal protective clothing when carrying out their duties. The chemical provider completes a functional test on the dishwasher monthly. Chemicals are stored safely within the kitchen</p> <p>Staff working in the kitchen have food handling certificates and chemical safety training. On-line training is also completed.</p> <p>The chef manager receives feedback from resident meetings, surveys and from direct communication from residents.</p>
<p>Standard 1.3.2: Declining</p>	<p>FA</p>	<p>The reason for declining service entry to potential residents should this occur is communicated to the</p>

<p>Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>		<p>potential resident or family/ whānau and they are referred to the original referral agent for further information.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>The initial support plan is developed with information from the initial assessment. Clinical risk assessments are completed on admission where applicable and reviewed six monthly as part of the InterRAI assessment (link 1.3.3.3). Outcomes of risk assessment tools are used to identify the needs, supports and interventions required to meet resident goals.</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 long-term 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 with the exception of weight loss (link 1.3.6.1). Short-term care plans sighted in the resident files had been evaluated regularly and either resolved or transferred to the long-term care plan if an ongoing problem. 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>	<p>PA Moderate</p>	<p>When a resident's condition changes, the RN initiates a review and if required a GP or nurse specialist consultation. Relatives interviewed stated their relative's 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 stated their needs were being met. There were no documented interventions for three residents with weight loss.</p> <p>Adequate dressing supplies were sighted. Initial wound assessments with ongoing wound evaluations and treatment plans were in place for all wounds including chronic wounds and one stage-3 (hospital acquired) pressure injury. Wounds are re-assessed at least monthly. Photographs are taken of the chronic wounds and pressure injury. Evaluation comments were documented at each dressing change to monitor the healing progress. The clinical nurse leader and nurse manager confirmed there was a wound nurse specialist available as required. The GP reviews chronic wounds at the medical review and earlier</p>

		<p>on RN request.</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>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>	FA	<p>The service employs a fulltime recreational therapist (RT) who is a qualified caregiver. She has been in the role since October 2016 and is enrolled to commence diversional therapy training.</p> <p>The integrated rest home and hospital programme covers seven days a week. A designated caregiver coordinates the activity programme on the RT days off (Wednesday and Thursday). The programme has been reviewed in consultation with residents to include new activities of interest. Activities meet the recreational needs of both rest home and hospital residents and ensures all residents have the opportunity for outings, shopping, and attending community groups/events. Community visitors include monthly entertainers, pet therapy and weekly church services. The programme includes allocated time for daily room visits and one-on-one time. Festive events and themes are celebrated.</p> <p>Residents are encouraged to maintain community links. The service has a wheelchair van for outings.</p> <p>Monthly meetings provide an opportunity for residents to feedback on the programme. 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>	FA	<p>There is evidence of resident and family involvement in the review of resident centred care plans. All initial care plans were evaluated by the registered nurses within three weeks of admission. Written evaluations were completed six monthly or earlier for resident health changes in all long-term resident files reviewed. There is evidence of multidisciplinary (MDT) team involvement in the reviews including input from the GP and any allied health professionals involved in the resident's care. Families are invited to attend the MDT review and asked for input if they are unable to attend. Short-term care plans sighted have been evaluated by the RN. The GP completes three monthly reviews.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access</p>	FA	<p>Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The service provided examples of where a resident's condition had changed and the resident was reassessed for a higher level of care.</p>

or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.		
<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	<p>Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Safety datasheets are readily accessible for staff. Chemicals were stored safely throughout the facility. A chemical spills kit is available. Personal protective clothing is available for staff and seen to be worn by staff when carrying out their duties on the day of audit. Relevant staff have completed chemical safety training.</p>
<p>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 two storey building has a current building warrant of fitness that expires on 1 February 2017. A full-time property manager and property assistant maintain a planned maintenance programme and attend to daily maintenance and repairs. All maintenance requests are generated through the 'Sway' (Summerset way) on-line system. All electrical equipment has been tested and tagged. Clinical equipment has had functional checks/calibration annually. Hot water temperatures have been tested and recorded monthly with readings below 45 degrees Celsius. Preferred contractors for essential services are available 24/7. Environmental improvements include the extension of the recreational area on the ground floor and creating a separate cinema lounge for all residents to use.</p> <p>The care centre is located on the first floor. Serviced apartments are on the ground and first floor. Corridors are wide in all areas to allow residents to pass each other safely. There is safe access to all communal areas and outdoor areas. There is an outdoor balcony on the first floor with seating and shade. The external areas are well maintained.</p> <p>The caregivers and registered nurses (interviewed) stated 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</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. Thirty-seven bedrooms in the care centre and all serviced apartments have a full ensuite.</p>

<p>adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>		<p>Four bedrooms without ensuites are closely located to communal toilet/shower facilities. 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>	<p>FA</p>	<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>	<p>FA</p>	<p>Communal areas within the facility include a large main lounge that can accommodate rest home and hospital level residents and where most activities take place. There is a family room with tea making facilities. There is a spacious open plan dining room. There are seating alcoves within the facility. The communal areas are easily accessible for residents within the care centre and rest home level of care residents in serviced apartments.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. All linen and personal clothing is laundered on-site in the main laundry on the ground floor. The serviced apartment caregiver on duty undertakes laundry duties. There are designated cleaning staff on duty each day. 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 care centre has a sluice room with a laundry chute to deliver dirty linen to the downstairs laundry. 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. 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>Appropriate training, information and equipment for responding to emergencies are provided. Emergencies, first aid and CPR are included in the mandatory in-service programme. Summerset Falls has an approved fire evacuation plan and fire drills occur six monthly. Smoke alarms, sprinkler system and exit signs are in place. Civil defence and emergency training was provided in February 2016. There are staff at the facility 24/7 with a current first aid certificate. The facility is well prepared for civil emergencies and has emergency lighting, a store of emergency water and a gas BBQ for alternative heating and cooking. Emergency food supplies sufficient for three days are kept in the kitchen. There is a store cupboard of supplies necessary to manage a pandemic. The call bell system is available in all areas with indicator panels in each area. There are emergency management plans in place to ensure health, civil defence and other emergencies. 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. Heat pumps are also used as air conditioning units. Ceiling panels in resident rooms are controlled by individual thermostats.</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, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The infection control programme is appropriate for the size and complexity of the service. There is an infection control responsibility policy that includes responsibilities for the infection control officer. The infection control officer (registered nurse) has a signed job description and has been in the role two years. 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> <p>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. A public noticeboard within the care centre keeps residents and visitors updated on infection control matters.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human,</p>	FA	<p>The infection control officer attends an annual Summerset training day for infection control officers. The infection control officer also attended external training annually provided by an external infection control specialist.</p>

<p>physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>		<p>The infection control committee meets quarterly and is representative of staff from the clinical and housekeeping area. Meeting minutes document discussion around infection control data, trends and analysis of infections and corrective actions.</p> <p>The infection control officer and committee have access to an infection control nurse specialist at the DHB, external infection control consultant, public health, laboratory, GPs 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>	<p>FA</p>	<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. The infection control policies link to other documentation and cross reference where appropriate.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The infection control officer is responsible for coordinating and providing education and training to staff. The induction package includes specific training around hand washing competencies and standard precautions. Ongoing training occurs annually as part of the training calendar set at head office.</p> <p>Resident education occurs as part of providing daily cares. Care plans can include ways to assist staff in ensuring this occurs.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been</p>	<p>FA</p>	<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 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</p>

specified in the infection control programme.		<p>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).</p> <p>There has been one outbreak of confirmed norovirus in December 2015. Relevant authorities were notified. The service identified a shortfall around available supplies for the management of an outbreak. The level of supplies has been increased as sighted on the day of audit.</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 one hospital resident assessed as requiring the use of restraint (lap belt) and there were no residents requiring enablers. The resident care plan reviewed was up-to-date and provided the basis of factual information in assessing the risks of safety and the need for restraint. Ongoing consultation with the resident and family/whānau is also identified. 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 clinical nurse leader (who was currently acting as the nurse manager). All staff are required to attend restraint minimisation training annually, which last occurred in March 2016.</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>	FA	<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. The reviewed 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</p>	FA	<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</p>

Use Services use restraint safely		resort. The restraint assessment and ongoing 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.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	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.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The restraint programme, including reviewing policies and procedures and staff education is evaluated annually by the national clinical and quality manager

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 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	PA Low	<p>Initial assessments had been completed within required timeframes in seven of seven files reviewed. The five RNs, clinical nurse leader and nurse manager are InterRAI competent. The InterRAI assessment tool has been embedded as part of the six-monthly evaluation process for long-term residents who have been at the service six months or earlier due to significant health changes. InterRAI assessments had not been completed for all admission since 1 July 2015. Three long-term residents (one hospital and two rest home) did not have InterRAI assessments completed within 21 days of admission.</p>	<p>Three long-term residents (one hospital and two rest home) did not have InterRAI assessments completed within 21 days of admission.</p>	<p>Ensure InterRAI assessments are completed within 21 days of admission.</p> <p>90 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the</p>	PA Moderate	<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, repositioning chart, behaviour log and neurological observations. Short-term care plans were sighted for short-term changes, however there were no short-term care plans or intervention documented for three residents with weight loss.</p>	<p>There were no documented or implemented interventions for three residents (two hospital and one rest</p>	<p>Ensure interventions are documented/implemented for residents with unintentional weight loss.</p> <p>60 days</p>

consumers' assessed needs, and desired outcomes.			home) with unintentional weight loss.	
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.	CI	Surveillance results are used to identify infection control activities and education needs within the facility. In January 2016, the service commenced a project to reduce the number of respiratory tract infections.	The infection control officer and committee developed an action plan to reduce respiratory infections in 2016. The action plan included increased education and awareness around the prevention and spread of infection for staff, residents and visitors. This was achieved by a) increased infection control education for staff including increase in hand hygiene audits, b) resident education on infections/influenza vaccines at the resident meetings, c) the development of a public infection control noticeboard in the care centre with available information/graphs and data around infection control, d) display of colourful infection control posters which are changed regularly to ensure staff and resident/visitor awareness is maintained, e) staff encouraged to have influenza vaccines and f) infection control updates, data and education reminders placed on time target. The service has been successful in reducing the number of respiratory infections from 22 in 2015 to nine to date for 2016.

End of the report.