# Summerset Care Limited - Summerset on the Coast

## 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:

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| **Legal entity:** | Summerset Care Limited |
| **Premises audited:** | Summerset on the Coast |
| **Services audited:** | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) |
| **Dates of audit:** | Start date: 23 February 2017 End date: 24 February 2017 |
| **Proposed changes to current services (if any):** | |

**Total beds occupied across all premises included in the audit on the first day of the audit:** 39

# 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 |
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| | 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 |
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| | 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 the Coast provides rest home and hospital (geriatric and medical) level care for up to 44 residents. On the day of the audit there were 39 residents.

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 and staff.

The village manager is appropriately qualified and experienced and is supported by a 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. The residents and relatives interviewed spoke positively about the care and support provided.

This audit identified an area for improvement around care plan interventions.

The service is commended for achieving two continual improvement ratings relating to good practice, community involvement, planned activities and infection surveillance.

## Consumer rights

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| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. | | All standards applicable to this service fully attained with some standards exceeded. |

Summerset on the Coast 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

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. | | Standards applicable to this service fully attained. |

Summerset on the Coast 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

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| 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. |

The service has assessment processes and resident's needs are assessed prior to entry. There is a well-developed information pack available for residents and families/whānau at entry. Assessments, resident centred care plans and evaluations were completed by the registered nurses within the required timeframes. Risk assessment tools and monitoring forms were available and implemented. Resident centred care plans were individualised and reflected the involvement of allied health professionals in the care of the resident.

A diversional therapist coordinates and implements an integrated activity programme. She is supported by a part-time recreational therapist. The activities meet the individual recreational needs and preferences of the consumer groups. There are outings into the community and visiting entertainers.

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

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

## Safe and appropriate environment

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| 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 are stored safely throughout the facility. The building has a current warrant of fitness. Resident bedrooms are spacious and personalised. There are sufficient numbers of 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/laundry staff maintain a clean and tidy environment. All laundry and linen was completed on-site. There is plenty of natural light in all rooms and the environment was comfortable with adequate ventilation and heating.

## Restraint minimisation and safe practice

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. | | Standards applicable to this service fully attained. |

There are documented policies and procedures around restraint use and use of enablers. Currently there are three residents using restraint and one resident with an enabler. Staff training around the use of restraint and enablers is provided and staff interviewed understand the philosophy of minimal use.

## Infection prevention and control

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

The infection control programme is appropriate for the size and complexity of the service. The infection control officer (enrolled nurse) is responsible for coordinating and providing education and training for staff. The infection control officer and infection control committee have 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 Summerset 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) |
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| **Standards** | 3 | 46 | 0 | 1 | 0 | 0 | 0 |
| **Criteria** | 4 | 96 | 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) |
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| **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 |
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| Standard 1.1.1: Consumer Rights During Service Delivery<br><br>Consumers receive services in accordance with consumer rights legislation. | FA | Discussions with staff (four caregivers, two registered nurses (RN), and one diversional therapist) confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Eight residents (four rest home and four hospital) and three relatives (three hospital) were interviewed and confirmed the services being provided are in line with the Code. Observation during the audit confirmed this in practice. |
| Standard 1.1.10: Informed Consent<br><br>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Informed consent processes were discussed with residents and families on admission. Written general and specific consents were evident in the seven resident files reviewed (three rest home including one respite care and four hospital level of care including one respite care). Four caregivers and two 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.<br><br>Discussion with family members (three hospital) identifies that the service actively involves them in decisions that affect their relative's lives. Five long-term admission agreements and two short-term |

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| | | admission agreements (for the respite residents) were sighted and had been signed on admission. |
| Standard 1.1.11: Advocacy And Support<br>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | 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. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources<br>Consumers are able to maintain links with their family/whānau and their community. | 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. Relatives and friends are encouraged to be involved with the service and care. Residents, relatives and staff enjoyed a village health promotion day coordinated by nursing students. |
| Standard 1.1.13: Complaints Management<br>The right of the consumer to make a complaint is understood, respected, and upheld. | 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. Three complaints were received in 2016. All 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 because 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. |
| Standard 1.1.2: Consumer Rights During Service Delivery<br>Consumers are informed of their rights. | 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 |

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| | | information pack and is available at reception. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect<br><br>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | Staff interviewed could 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 can 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 February 2017. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs<br><br>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. | FA | 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. Staff interviewed could describe how they can ensure they meet the cultural needs of residents. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs<br><br>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | 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 consider their culture and values. |
| Standard 1.1.7: Discrimination<br><br>Consumers are free from any discrimination, coercion, harassment, sexual, financial, | FA | 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, nurse manager and caregivers confirmed an awareness of professional boundaries. |

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| or other exploitation. | | |
| Standard 1.1.8: Good Practice<br><br>Consumers receive services of an appropriate standard. | CI | 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.<br><br>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. The service has been awarded a continuous improvement around end of life care and support. |
| Standard 1.1.9: Communication<br><br>Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents and family members stated they were welcomed on entry and were given time and explanation about services and procedures. Family members interviewed also stated they are informed of changes in the resident's health status and incidents/accidents. Resident meetings are held monthly. An advocate from Age Concern attends the meetings. The village manager and the nurse manager have an open-door policy.<br><br>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. |
| Standard 1.2.1: Governance<br><br>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The service provides care for up to 44 residents at hospital (medical and geriatric) and rest home level care. At the time of the audit, there were 39 residents in total, 12 residents at rest home level including one respite care resident and 27 residents at hospital level including one respite care resident. 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 Aged Related Residential Care (ARCC) contract.<br><br>Summerset on the Coast has a site-specific business plan 2017 and goals that is developed in consultation with the village manager, nurse manager and regional operations manager. The Summerset on the Coast quality plan is reviewed regularly throughout the year. There is a full evaluation at the end of |

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| | | the year.<br><br>The village manager has been in the position for 18 months. The village manager is supported by a nurse manager and clinical nurse leader. The nurse manager has been in the position for six months and has a background in aged care nursing. There is a regional operations manager who is available to support the facility and staff. 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. |
| Standard 1.2.2: Service Management<br><br>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. | FA | During a temporary absence, the nurse manager will cover the village manager's role. The regional operations manager and the regional 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. |
| Standard 1.2.3: Quality And Risk Management Systems<br><br>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | Summerset on the Coast 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.<br><br>The Summerset group has a 'clinical audit, training and compliance' calendar. The calendar schedules the training and audit requirements for the month and the nurse manager completes a 'best practice' sheet confirming completion of requirements. The best practice sheet reports (but not limited to): meetings held, induction/orientation, audits, competencies and projects. This is forwarded to head office as part of the ongoing monitoring programme. 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 2016) reports overall 93.2% feedback of experience being good or very good.<br><br>The service is implementing an internal audit programme that includes aspects of clinical care. Issues arising from internal audits are developed into corrective action plans. Monthly and annual analysis of |

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| | | 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 regional quality manager analyses data collected via the monthly reports, and corrective actions are required based on benchmarking outcomes.<br><br>There is a health and safety and risk management programme in place including policies to guide practice. The office manager is the health and safety officer (interviewed). In 2016 Summerset implemented a risk management and safety system (RMSS), with enhanced reporting, investigation, workflow management of Health and Safety. Summerset on the Coast introduced a site-specific health and safety plan, which included enhancing contractor safety, improving staff safety, reducing staff injuries, increase of training and education for staff on health and safety, improving the number of hazards and near misses reported and preparedness for an emergency.<br><br>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. |
| Standard 1.2.4: Adverse Event Reporting<br><br>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | Incident and accident data has been collected and analysed. Discussions with the service confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Twelve resident related incident reports for February 2017 were reviewed (four falls, three skin tears, four bruises and one other). 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. |
| Standard 1.2.7: Human Resource Management<br><br>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | There are human resources policies to support recruitment practices. A list of practising certificates is maintained. Eight staff files (one nurse manager, one RN, one clinical nurse leader, one diversional therapist, one housekeeper, one office manager/health and safety officer 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 three newly appointed staff).<br><br>Staff interviewed could 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 |

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| | | 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. |
| Standard 1.2.8: Service Provider Availability<br><br>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The village manager and nurse manager work 40 hours per week (Monday to Friday). The village manager is available on call for any operational issues. The nurse manager and clinical nurse leader (CNL) share the on-call responsibilities for clinical support. The service provides 24-hour RN availability. There are six caregivers on morning shifts, six on the afternoon shifts and two on night shifts. A staff availability list ensures that staff sickness and vacant shifts are covered. 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. Residents and relatives interviewed stated that there was sufficient staff available. |
| Standard 1.2.9: Consumer Information Management Systems<br><br>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident files were appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access by being held in a locked cupboard. Care plans and notes were legible and where necessary signed (and dated) by a registered nurse. Entries are legible, dated and signed by the relevant care assistant or registered nurse, including designation. Individual resident files demonstrate service integration. There is an allied health section that contained general practitioner notes and the notes of allied health professionals and specialists involved in the care of the resident. |
| Standard 1.3.1: Entry To Services<br><br>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | 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.<br><br>Residents (four rest home including one respite resident and four hospital) and relatives (three hospital) 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 |

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| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer<br><br>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | There is an exit, discharge and transfer policy that describes guidelines for death, discharge, transfer, documentation and follow-ups. This directs staff to the appropriate documentation. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities. Follow-up occurs to check that the resident is settled or, in the case of death, communication with the family is made. |
| Standard 1.3.12: Medicine Management<br><br>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal and medicine reconciliation in line with accepted guidelines. Registered nurses including clinical nurse leader and two enrolled nurses administer medication and all have current medication competencies and have received medication education. Medication errors, allergies are documented and investigated. The service medication management system follows recognised legislative requirements and guidelines for safe medicine management practice.<br><br>The service uses monthly robotic medication rolls. Medications are checked on arrival at the facility. All medications are stored safely. The medication fridge temperature is recorded daily and maintained within the acceptable range. Three registered nurses and one enrolled nurse interviewed were conversant with the service medicine management policies procedures. Six monthly medication audits have been completed. There is a self-medicating resident's policy available to guide staff practice if required. There are currently no residents self-administering medicines. There are currently no medication standing orders<br><br>Fourteen resident medication charts were reviewed on the electronic medication system and all had photographs and allergy status documented. All medication charts reviewed met legislative prescribing requirements and have been reviewed at least three monthly by the GP. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management<br><br>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The kitchen supplies all meals for the facility and is cooked on site by a contracted service. There is evidence of current council certificate that expires 30 June 2017. All kitchen staff have been trained in safe food handling. On admission, the registered nurse completes a dietary profile and communicates individual resident's needs to the kitchen staff. The chef manager and kitchenhand interviewed described the process of special dietary requirements of individual residents and how they meet these needs. Residents with special dietary needs have these needs reviewed as part of the six-monthly care planning review process. There is a daily cleaning schedule in place. Kitchen fridge, freezer and food temperatures are monitored daily and are within acceptable limits. All food in the fridge and pantry is dated and labelled and all pantry items are stored off the floor. Two staff interviewed were aware of safe management of incidents/accidents, hazard management and have completed chemical safety training. |

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| | | The menu is an eight-week cycle and has been reviewed by a dietitian. The service has access to a DHB dietitian and is contacted for any issues.<br><br>Residents report satisfaction with the food choices, meals are well presented (observed) and alternative meals are offered as required. |
| Standard 1.3.2: Declining Referral/Entry To Services<br><br>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. | FA | The reason for declining service entry to residents should this occur, is communicated to the resident or family/whānau and they are referred to the original referral agent for further information. |
| Standard 1.3.4: Assessment<br><br>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | The initial support plan is developed with information from the initial assessment and information provided from discharge summaries, allied health professionals and in consultation with the resident/relatives.<br><br>Continuing needs/risk assessments are carried out by registered nurses. Assessment outcomes and goals for residents are identified and link to resident-centred care plan. Care plans include falls assessments, wound care and weight loss. InterRAI assessments are used as the generalised assessment tool six monthly and within 21 days of admission. |
| Standard 1.3.5: Planning<br><br>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Low | Overall resident-centred care plans described the individual support and interventions required to meet the resident goals. The care plans reflect the outcomes of risk assessment tools. Care plans demonstrate service integration and include input from allied health practitioners. Short-term care plans were in use for changes in health status. These are evaluated regularly and either resolved or if an ongoing problem, added to the long-term care plan. There is documented evidence of resident/family involvement in the care planning process. Residents/relatives interviewed confirmed they participate in the care planning process. |
| Standard 1.3.6: Service Delivery/Interventions<br><br>Consumers receive adequate | FA | When a resident’s condition changes, the RN initiates a review and if required a GP or nurse specialist consultation (link 1.3.5.2). Relatives interviewed state 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 |

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| and appropriate services in order to meet their assessed needs and desired outcomes. | | notification of any changes to health including infections, accidents/incidents, and medication changes. Residents interviewed state their needs are being met.<br><br>Adequate dressing supplies were sighted. Initial wound assessments with ongoing wound evaluations and treatment plans were in place for seven residents with wounds and two hospital level residents with pressure injuries (one stage-one facility acquired and one unstageable hospital acquired). The CNL and RN described the referral process for wound nurse specialist involvement through the DHB and district nurses. The nurse practitioner is available to provide advice and support on wound management.<br><br>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. Risk assessment tools and monitoring forms are available and are used to effectively assess changes in level of risk and required supports for residents.<br><br>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, and food and fluid intake charts. RNs review the forms/charts and completed risk assessments for any changes to health. |
| Standard 1.3.7: Planned Activities<br><br>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. | CI | The service employs a fulltime diversional therapist (DT) and part-time qualified caregiver who is progressing though DT qualifications. The DT is a member of the DT society, attends the regional support group and the DT conference. The activity team also attend Summerset training sessions. Both team members have a current first aid certificate.<br><br>The integrated resident-centred rest home and hospital programme covers seven days a week from 9am to 4pm. The programme is planned a month in advance and includes set activities with the flexibility to add other activities of interest or suggestions made by residents. Following feedback, activities now provide a more holistic approach and have focused on increasing resident participation, resident interests and community inclusion (link 1.1.12.2). Activities include (but not limited to); sit and be fit exercises, creative cooking, arts and crafts, reminiscence, movies, music, walks and one-on-one therapy. Residents were observed being actively involved with a variety of activities. Activities are planned that are appropriate to the functional capabilities of residents. Residents are encouraged to maintain their former community links. Community visitors include entertainers, church services, canine therapy and outings.<br><br>Three monthly resident meetings and annual surveys provide an opportunity for residents to feedback on the programme.<br><br>The DT is involved in the multidisciplinary review which includes the review of the activity plan. |

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| Standard 1.3.8: Evaluation<br><br>Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Documented evaluations are completed at care plan review that reviews progress to meeting resident goals. There is at least a three-monthly review by the medical practitioner. Long-term resident-centred care plans are evaluated by the registered nurses six monthly or when changes to care occur as sighted in five of seven long-term care plans reviewed. Two residents had not been at the service long enough for a care plan evaluation. There are short-term care plans to focus on acute and short-term issues. Changes to the long-term resident-centred care plans are made as required (link 1.3.6.1) and at the six-monthly review as required. Short-term care plans reviewed were well used, comprehensive, evaluated for effectiveness and signed off once resolved.<br><br>All initial care plans were evaluated by the RN within three weeks of admission. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)<br><br>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | Discussions with registered nurses identified that the service has access to (but not limited to); dietitian, physiotherapist, wound care nurse specialist, nurse practitioner, hospital specialists. 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. One resident file reviewed provided an example of where a resident's condition had changed and the resident was reassessed for a higher level of care. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances<br><br>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Safety datasheets were readily accessible for staff. Chemicals were stored safely throughout the facility. Personal protective clothing was available for staff at the point of use in the two sluice rooms. Staff were seen to be wearing personal protective equipment when carrying out their duties on the day of audit. Relevant staff have completed chemical safety training. |
| Standard 1.4.2: Facility Specifications | FA | The building has a current building warrant of fitness that expires on 9 February 2018. There is a full-time property manager who oversees the property assistant and gardening team and is available on call for facility matters. The property manager is the health and safety representative for Summerset on the |

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| Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | | health and safety committee. Staff complete maintenance requests through the Sway (Summerset way) on-line system (property services requests).<br><br>Electrical equipment has been tested and tagged December 2016 by an external contractor. Clinical equipment has had functional checks/calibration annually. Hot water temperatures are randomly tested in bathrooms and hand basins monthly. Corrective actions have been recorded for temperatures outside of the acceptable range. Contractors check the temperatures of cylinders three monthly. Preferred contractors for essential services are available 24/7.<br><br>The building has a ground floor where the care centre is located and first floor with offices and staff area. Corridors are wide in all areas to allow residents to pass each other safely. There is safe access to all communal areas, outdoor areas and gardens with seating and shade. The external areas are well maintained.<br><br>Environmental improvements include flooring replacement plan for vinyl in bedrooms as rooms are refurbished, replacement of kitchen vinyl, upgrading and refurbishment of the dining room, converted and upstairs lounge into a family/whānau room, reconfigure a large lounge extension into two spacious single rooms, upgrading (painting and wallpaper) of communal hallways and manual hi-lo bed replacement programme.<br><br>The caregivers and registered nurses (interviewed) state they have all the equipment required to safely provide the care documented in the care plans. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities<br><br>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | All bedrooms have hand basins. There are sufficient numbers of shower and toilet facilities in each of the three wings of resident rooms. Visual inspection evidences toilet and shower facilities are of an appropriate design to meet the needs of the residents. 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. Privacy curtains are in shower rooms. |
| Standard 1.4.4: Personal Space/Bed Areas<br><br>Consumers are provided with adequate personal space/bed | FA | All resident rooms (including the two additional rooms) are single and spacious enough 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. |

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| areas appropriate to the consumer group and setting. | | |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining<br><br>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | Communal areas within the facility include a large main lounge that is partitioned from a smaller lounge with doors that open to the outdoors. There is a conservatory lounge at the end of each wing. The rest home wing of nine beds has its own dining room with kitchenette and tea making facilities. There are seating alcoves throughout the facility. The communal areas are easily accessible for residents or with the assistance of staff. |
| Standard 1.4.6: Cleaning And Laundry Services<br><br>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. All linen and personal clothing is laundered on-site. There are designated cleaning/laundry staff on duty seven days a week. There is an entry and exit door with a defined clean/dirty area. The laundry is well equipped and all machinery has been serviced regularly.<br><br>Cleaning trolleys sighted were well equipped and are kept in designated locked areas when not in use. There are locked chemical boxes securely fixed to the cleaning trolley. External (chemical provider) and internal audits monitor the effectiveness of laundry and cleaning processes. |
| Standard 1.4.7: Essential, Emergency, And Security Systems<br><br>Consumers receive an appropriate and timely response during emergency and security situations. | FA | There is an emergency and civil defence plan to guide staff in managing emergencies and disasters. Emergencies and first aid is included in the mandatory in-service programme. There is a first aid trained staff member on every shift. Summerset on the Coast has an approved fire evacuation plan and fire drills occur six monthly. Smoke alarms, sprinkler system and exit signs are in place. The service has alternative cooking facilities (barbeque) available in the event of a power failure. There is a 2000 litre tank, stored bottled water and lake water for use in an emergency. The service holds at least three days of food storage. The civil defence equipment has been relocated from the garage to a central glow in the dark cabinet within the facility. Emergency power is used for lighting and calls bells for up to two hours with torches readily available and solar lights that can be accessed from the garden areas.<br><br>Call bells were evident in resident's rooms including the two reconfigured rooms, lounge areas, and toilets/bathrooms. Staff use walkie talkies. The facility is secured at night and the front gates are locked after hours with buzzer access. |

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| Standard 1.4.8: Natural Light, Ventilation, And Heating<br><br>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | Visual inspection evidences that the residents have adequate natural light in the bedrooms and communal rooms, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. The facility has underfloor heating in all areas. |
| Standard 3.1: Infection control management<br><br>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. | FA | 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 who is an enrolled nurse and has been in the role 13 years. The infection control programme is linked into the quality management system and reviewed annually in March at head office and in consultation with the infection control committee. The facility meetings include a discussion of infection control matters.<br><br>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. |
| Standard 3.2: Implementing the infection control programme<br><br>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The infection control officer attends an annual Summerset training day for infection control officers and attends three monthly teleconferences and DHB meetings. The infection control officer is supported by an infection control committee, which consists of representatives from the clinical, food services and housekeeping areas. Committee members have attended the DHB infection control meetings. Committee meetings are held monthly.<br><br>The facility has access to an infection control nurse specialist at the DHB, public health, laboratory, GPs and are supported by the regional manager who is a registered nurse. |
| Standard 3.3: Policies and procedures<br><br>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily | FA | There are comprehensive infection control policies that are current and reflected the Infection Control Standard SNZ HB 8134:2008, legislation and good practice. These are across the Summerset organisation and are reviewed regularly at head office. The infection control policies link to other documentation and cross reference where appropriate. |

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| available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | | |
| Standard 3.4: Education<br>The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | 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. Staff are required to complete practical hand hygiene audits and an infection control questionnaire. Ongoing training has occurred three times throughout the year for all staff. Resident education occurs as part of providing daily cares. |
| Standard 3.5: Surveillance<br>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | CI | 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. Committee meeting minutes and graphs are displayed on the infection control board.<br>Infection control internal audits are completed and corrective actions raised for non-compliance. There has been one confirmed norovirus outbreak in January 2016. Relevant authorities were notified. The service identified the need to increase outbreak management supplies and set up an outbreak cupboard. |
| Standard 2.1.1: Restraint minimisation<br>Services demonstrate that the use of restraint is actively minimised. | FA | There are policies around restraints and enablers. The service currently has three residents assessed as requiring the use of restraint (three bed rails) and one requiring enablers (bedrails). The care plans provide 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. |
| Standard 2.2.1: Restraint approval and processes<br>Services maintain a process for determining approval of all types of restraint used, restraint | FA | A restraint approval process and a job description for the restraint coordinator are in place. The restraint coordinator role is delegated to the nurse manager. All staff are required to attend restraint minimisation training annually. |

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| 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. | | |
| Standard 2.2.2: Assessment<br>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | Only registered nursing staff can assess the need for restraint. Restraint assessments are based on information in the resident's care plan, discussions with the resident and family and observations by staff. A restraint assessment tool meets the requirements of the standard. Two hospital level residents' files where restraint was being used were selected for review. Each file included a restraint assessment and consent form that was signed by the resident's family. Restraint use is linked to the resident's care plan and is regularly reviewed. |
| Standard 2.2.3: Safe Restraint Use<br>Services use restraint safely | FA | A restraint register is in place. The register identifies the residents that are using a restraint, and the type(s) of restraint used. The restraint assessment identified that restraint is being used only as a last resort. The restraint assessment and 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<br>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<br>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 quality manager and the national education 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) |
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| Criterion 1.3.5.2<br>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing | PA Low | Overall resident-centred care plans described the individual support and interventions required to meet the resident goals, however four resident files reviewed did not include all interventions to support current | Four resident files reviewed (two rest home residents, one rest home respite care and one hospital respite level of care resident) did not all include interventions to support current needs. 1) The hospital level respite care resident was assessed at medium risk of falls, had swallowing difficulties and on a soft diet. There were no documented interventions to manage the falls risk and dietary requirements/swallowing difficulties. No weight had been recorded on admission. 2) There were no documented signs/symptoms treatment and management for hypoglycaemia episodes as per discharge summary. 3) One rest home resident has been diagnosed with a new medical condition with associated pain as per GP notes. There were no documented interventions for the newly diagnosed condition or pain management plan in place. 4) One other rest home resident had no documented interventions for a medication that requires close monitoring (as per GP notes). | Ensure resident current health needs are documented to guide staff in the delivery of care and to meet the resident needs. |

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| assessment process. | | needs. | | 90 days |

# Specific results for criterion where a continuous improvement has been recorded

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

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

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

| Criterion with desired outcome | Attainment Rating | Audit Evidence | Audit Finding |
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| Criterion 1.1.12.2<br>Consumers are supported to access services within the community when appropriate. | CI | The service promotes community visitors to the village and encourage resident involvement. Summerset on the Coast have a long-term relationship with Whitireia students and supported a health promotion day held in the village August 2016. | Whitireia nursing students identified an opportunity to hold a health promotion day “Whitireia Health Fair” in the village for all village residents, care centre residents and staff. The expo had a holistic approach including nutrition, activities, information technology, dental health, physical health and falls prevention. There were a number of stalls and blood pressure checks. The interaction of nursing students, village and care centre residents, staff and families created a strong sense of community for all those who attended. Thirty-two residents (ambulatory and assisted) from the care centre, attended the health promotion expo and expressed extreme satisfaction as documented in articles published in the local newspaper. A nursing student published an article on the health promotion day in the nursing journal. |
| Criterion 1.1.8.1<br>The service provides an environment that | CI | The service identified a key project for 2016 around the very end stage of life and care after death including supporting | The clinical nurse leader (CNL) took on a role as a champion of end of life and facilitated and directed all end of life care planning. The service has a close relationship with the hospice. Palliative care training packages were completed by care staff. Training was also completed by the administration staff as they are often the first person to meet families with a loved one at the end of life or following death. Caregivers focus has |

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| encourages good practice, which should include evidence-based practice. | | families and staff. Guidelines were developed around the last few days of life, physical death, extended family support, mental and spiritual health in line with the DHB focus on palliative care (Te Ara Whakapiri). | changed from meeting physical needs to providing comfort and support and state they feel more comfortable discussing end of life and supporting families. A resident advocate provides feedback on the services. A chaplain has been formally engaged who supports the end of life resident and their families before and after death including prayers and the blessing of rooms. Other initiatives around end of life include: the provision of a family/whānau room, a comfort box (with contents such as soft music DVS, toiletries, candle, bible and shawl) and the development of a special palliative care menu to ensure suitable food and fluids are provided. A comprehensive package for families "support for your loved one" has been created. When a casket is removed, the last journey is through the front door where all staff on duty form a guard of honour. Letters of thanks reflect the satisfaction level of families in the care and support at end of life. In 2016 there were 33 deaths. Verbal feedback has been received from the families with a 97% satisfaction rate. The resident/relative survey October 2016 evidenced 100% satisfaction for care. |
| Criterion 1.3.7.1<br>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | CI | The 2015 survey identified that residents would like a more holistic programme (based around children, pets and plants) that would engage the residents, provide more spiritual services, and more music (50% enjoyed entertainers and 44% enjoyed music) and implement an intergenerational programme. | A project commenced January 2016 to improve the activity programme to meet the expectations of the residents around engaging residents in the programme, provision of music and entertainment and more spiritual services. This was achieved by; a) employing a qualified DT to facilitate the activity programme to meet the residents preferences, b) meeting with residents to discuss their recreational preferences and listen to suggestions for activities, c) purchasing a piano with relative input that is played by a resident daily and for the village choir rehearsals, d) placement of a university music therapist for six months, e) introduction of a school boys weekly mentoring programme, which included engaging with residents and sharing of life stories and entertainment such as kapa haka group, f) engaging a dedicated chaplain to increase church services and be available to all and g) garden development to increase indoor/outdoor flow and resident interaction with the garden and resident cat.<br>The 2016 survey showed .01% increase from 2015, however the service identified the low response rate due to a higher number of hospital residents who were unable to participate in the survey. Evidence of increased satisfaction in the programme has been through monitoring the resident attendance, and resident DT progress notes that document resident satisfaction and increased participation in the programme. Attendance records evidence residents who once stayed in their rooms now come out for activities, entertainment and music. Residents interviewed on the day of audit stated they were very satisfied with the improved activities, entertainment, music and visiting school children and spiritual services. |

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| Criterion 3.5.7<br><br>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 | Infection events are collated monthly and areas for improvement are identified and corrective actions developed and followed up. The facility is benchmarked against other Summerset facilities of similar size and benchmarking results are fed back to the infection control officer and used to identify areas for improvement. Surveillance results are used to identify infection control activities and education needs within the facility. The service has successfully reduced urinary tract infections (UTI). | The service identified a peak in UTIs in October 2016 with six UTIs for the month from one the previous month before. An analysis of the residents with UTIs identified all residents were female, had positive E Coli urine samples and all residents used commodes in their rooms. The infection control officer focused on education for caregivers around perineal cleaning and ensuring residents had adequate fluid intake in a variety of forms such as ice-blocks and jellies. The graphs displayed were produced in a user-friendly format that could be easily interpreted by care staff. The infection control board was used more frequently to increase staff awareness around prevention of UTIs. In November 2016, the UTIs had reduced to two and have remained below the organisational key performance indicator (KPI). Over 2016 Summerset on the Coast has the second lowest incidence of UTIs in the rest home across the organization. The service has successfully reduced and maintained the incidence of UTIs in rest home residents below the organisational KPI (1.5 per 1000 bed days) for UTIs. |

End of the report.