

Summerset Care Limited - Summerset At Bishopscourt

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 At Bishopscourt
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 1 March 2017 End date: 2 March 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:	42



Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Summerset at Bishopscourt provides rest home and hospital level care for up to 63 residents. On the day of the audit there were forty-two residents including two rest home residents in serviced apartments. The service is managed by a village manager and a nurse manager. The residents and relatives interviewed spoke positively about the care and support provided.

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

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

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

The service has been awarded a continuous improvement rating around the activity programme and infection surveillance.

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.
--	--	--

The facility provides care in a way that focuses on the individual resident. There is a Māori health plan and cultural safety policy supporting practice. Cultural assessment is undertaken on admission and during the review process. The service functions in a way that complies with the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and related services is readily available to residents and families. Policies are available that support residents' rights. An advocate from Age Concern attends resident's meetings. 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 community.

Organisational management

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

Summerset at Bishopscourt implements a quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to a number of meetings including monthly quality improvement meetings. Annual surveys and monthly resident meetings provide residents and families with an opportunity for feedback about the service. Quality performance is reported to staff at meetings and includes discussion about incidents, infections and internal audit results. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care. There is a staffing policy in place.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		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, interventions and evaluations were completed by the registered nurses within the required timeframes. Risk assessment tools and monitoring forms were available and implemented. Resident-centred care plans were individualised and evidenced allied health professional involvement in the resident's care.

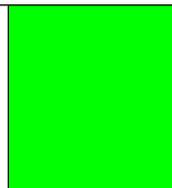
Two diversional therapists in training coordinate and implement an integrated activity programme based on resident preference and participation. The activities meet the individual recreational needs and includes community involvement, entertainment and visits into the community.

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

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.

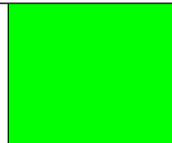


Standards applicable to this service fully attained.

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. Bedrooms have either single or shared ensuites. There is sufficient space to allow the movement of residents around the facility using mobility aids. 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 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. There were no residents requiring the use of a restraint or enabler at the time of audit.

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 coordinator (registered nurse) is responsible for coordinating and providing education and training for staff. The infection control coordinator 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 and also with two other large aged care providers.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	1	43	0	1	0	0	0
Criteria	2	90	0	1	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Discussions with nine staff (four care assistants, one enrolled nurse, three 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). Seven residents (four rest home and three hospital level of care) and one relative (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. Written general and specific consents were evident in the seven resident files reviewed (three rest home level of care including one resident in the serviced apartments and four hospital level of care including one resident under ACC funding). Four caregivers, one enrolled nurse and three 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) interviewed confirmed discussion occurs around resuscitation with families/EPOA where the resident was deemed incompetent to make a decision.</p> <p>Discussion with one relative of a hospital level of care resident identifies that the service actively involves them in decisions that affect their relative's lives. Seven admission agreements sighted were signed.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	Residents are provided with a copy of the Code on entry to the service. Residents interviewed confirmed they are aware of their right to access independent advocacy services and advocacy pamphlets are available at reception. Discussions with relatives confirmed the service provided opportunities for the family/enduring power of attorney (EPOA) to be involved in decisions. The resident files include information on residents' family/whānau and chosen social networks.
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. Activities programmes included opportunities to attend events outside of the facility including activities of daily living, for example, shopping and attending cafes and restaurants. Interview with staff, residents and relatives informed residents are supported and encouraged to remain involved in the community and external groups. Relative and friends are encouraged to be involved with the service and care.
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	The organisational complaints policy stated that the village manager has overall responsible for ensuring all complaints (verbal or written) are fully documented and investigated. There is an electronic complaint's register that included relevant information regarding the complaint. Documentation included follow-up letters and resolution were available. The number of complaints received each month is reported monthly to staff via the various meetings. There were five complaints received in 2016 (year to date). Four of the complaints documentation included follow-up letters and resolutions were completed within the required timeframes. One complaint remains open as the complainant (external) has not yet responded to the follow-up letter due to ill health. A complaints procedure is provided to residents within the information pack at entry. Feedback forms are available for residents/relatives in various places around the facility.
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	The service provides information to residents that include the Code, complaints and advocacy. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Residents and relatives interviewed identified they are well informed about the Code of Rights. Monthly resident meetings provide the opportunity to raise concerns. An annual residents/relatives survey is completed. Advocacy and Code of Rights information is included in the information pack and are available at reception. An advocate from Age Concern attends resident's meetings quarterly.

<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Staff interviewed were able to describe the procedures for maintaining confidentiality of resident records, resident's privacy and dignity. House rules and a code of conduct are signed by staff at commencement of employment. Contact details of spiritual/religious advisors are available. Resident files include cultural and spiritual values. Residents and relatives interviewed reported that residents are able to choose to engage in activities and access community resources. There is an elder abuse and neglect policy and 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 at Bishopscourt 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 audit there was one resident who identified as Māori. A review of the resident's file evidenced that cultural and spiritual values and needs were addressed. The resident was interviewed and expressed that her cultural and spiritual needs were respected and met. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with disability and other community representative groups as requested by the resident/family. Cultural needs are addressed in the care plan. Staff interviewed were able to describe how they can ensure they meet the cultural needs of Māori.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>An initial care planning meeting is carried out where the resident and/or whānau as appropriate/able are invited to be involved. Individual beliefs or values are further discussed and incorporated into the care plan. Six-monthly multidisciplinary team meetings occur to assess if needs are being met. Family are invited to attend. Discussion with relatives confirms values and beliefs are considered. Residents interviewed confirm that staff take into account their culture and values.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination,</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, nurse manager and registered nurses confirmed an awareness of professional boundaries. Caregivers</p>

<p>coercion, harassment, sexual, financial, or other exploitation.</p>		<p>discussed professional boundaries and attended training in December 2016.</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 very positively about the care and support provided. Staff have a sound understanding of principles of aged care and state that they feel supported by the village manager, nurse manager and clinical nurse lead. 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 as well as other external aged care providers. There is a culture of ongoing staff development with an in-service programme being implemented. There is evidence of education being supported outside of the training plan. Services are provided at Summerset that adhere to the Health & Disability Services Standards and all approved service standards are adhered to. There are implemented competencies for caregivers and registered nurses including but not limited to: insulin administration, medication, wound care and manual handling. RNs have access to external training. There is a family suite within the care centre which mostly caters for end of life residents.</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 health status of residents and incidents/accidents. Resident/relative meetings are held monthly with an advocate from Age Concern present at the meeting every three months. The village manager and the nurse manager have an open-door policy. The service produces a newsletter for residents and relatives. Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The service has policies and procedures available for access to interpreter services for residents (and their family/whānau). If residents or family/whānau have difficulty with written or spoken English, the interpreter services are made available.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of</p>	<p>FA</p>	<p>The service provides care for up to 63 residents at hospital (geriatric and medical) and rest home level care. There are 43 dual-purpose beds in the care centre on level one and 20 serviced apartment on the ground floor certified to provide rest home level care. On the day of the audit, there were 42 residents in total - 19 residents at rest home level (two are in the serviced apartments) and 23 residents at hospital level including two on ACC contracts. The two hospital level residents on ACC contracts are under the age of 65 years. The remaining residents were under the aged related contract.</p> <p>The Summerset Group Limited Board of Directors have overall financial and governance responsibility and</p>

<p>consumers.</p>		<p>there is a company strategic business plan in place.</p> <p>Summerset at Bishopscourt has a site-specific business plan and goals that is developed in consultation with the village manager, nurse manager and regional operations manager (ROM). The quality plan is reviewed regularly throughout the year. There is a full evaluation at the end of the year. The 2016 evaluation was sighted. The village manager has been in the current role at Summerset since 2013. The village manager is supported by a nurse manager. The nurse manager has been in the position for four weeks. The nurse manager is a registered nurse who holds a post graduate qualification in critical care neuro sciences and has experience of working in aged care in Australia. The nurse manager is supported by the clinical nurse lead. Village managers and nurse managers attend annual organisational forums and regional forums over two days. The nurse manager attends clinical education, forums/provider meetings at the Southern District Health Board. There is a regional operations manager who is available to support the facility and staff. The village manager has attended at least eight hours of leadership professional development relevant to the role.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>During a temporary absence, the nurse manager will cover the manager's role. The regional operations manager and the clinical quality manager provide oversight and support. The audit confirmed the service has operational management strategies and a quality improvement programme to minimise risk of unwanted events.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>Summerset at Bishopscourt is implementing the organisation's quality and risk management system. There are policies and procedures being implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed on a regular basis. The content of policy and procedures are detailed to allow effective implementation by staff.</p> <p>The Summerset group has a 'clinical audit, training and compliance' calendar. The calendar schedules the training and audit requirements for the month and the nurse manager completes a 'best practice' sheet confirming completion of requirements. The best practice sheet reports (but not limited to): meetings held, induction/orientation, audits, competencies and projects and 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</p>

		<p>discussion about clinical indicators (e.g. incident trends, infection rates). Registered nurse meetings are held monthly. Caregivers meetings are held fortnightly. Health and safety, infection control and restraint meetings occur three-monthly. There are other facility meetings held such as kitchen and activities. An annual residents/relatives survey completed (October 2016) reports overall 100% feedback of experience being good or very good.</p> <p>The service is implementing an internal audit programme that includes aspects of clinical care. Issues arising from internal audits are developed into corrective action plans. Monthly and annual analysis of results is completed and provided across the organisation. There are monthly accident/incident benchmarking reports completed by the nurse manager that break down the data collected across the rest home and hospital and staff incidents/accidents. Infection control is also included as part of benchmarking across the organisation. Health and safety internal audits are completed. Summersets clinical and quality manager analyses data collected via the monthly reports and corrective actions are required based on benchmarking outcomes. Somerset has a data tool "Sway- the Somerset Way". Sway is integrated and accommodates the data entered. There is a health and safety and risk management programme in place including policies to guide practice. The activities coordinator 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. The service introduced the "Use it or lose it" exercise programme in March 2016 to assist with improving resident balance and strength.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Incident and accident data has been collected and analysed. Discussions with the service confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Twelve resident related incident reports for February 2016 were reviewed (seven falls, four skin tears and one other category). All reports and corresponding resident files reviewed evidence that appropriate clinical care has been provided following an incident. The incident reporting policy includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Data is linked to the organisation's benchmarking programme and used for comparative purposes.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance</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 lead, one activities coordinator, one property manager and two caregivers) were reviewed and all had relevant documentation relating to employment. Performance appraisals had been completed annually for those staff who have been employed for over 12 months. 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</p>

<p>with good employment practice and meet the requirements of legislation.</p>		<p>induction checklists (sighted in files of newly appointed staff). Staff interviewed were able to describe the orientation process and believed new staff were adequately orientated to the service. There is an annual education plan that is outlined on the 'clinical audit, training and compliance calendar'. The plan is being implemented. A competency programme is in place with different requirements according to work type (e.g. care assistants, registered nurse and kitchen). Core competencies are completed and a record of completion is maintained on staff files and well as being scanned into 'Sway'.</p> <p>Staff interviewed were aware of the requirement to complete competency training. Caregivers complete an aged care programme. There are 26 permanent caregivers employed, all 26 have completed aged care qualifications.</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 clinical nurse lead works full time Sunday to Thursday. In the care centre, there is an RN on duty 24/7. There are six caregivers on morning shifts, six on the afternoon shifts and three on night shifts. An enrolled nurse is rostered to work one morning and four afternoon shifts per week. The RN on duty provides oversight to the rest home residents in the serviced apartments. One caregiver is on duty in the serviced apartments on a morning shift, an afternoon shift and a night shift to assist the two rest home residents.</p> <p>Staffing levels and skills mix policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery. A staff availability list ensures that staff sickness and vacant shifts are covered. Caregivers interviewed confirmed that staff are replaced when off sick.</p> <p>Interviews with residents and relatives confirmed that staffing levels are sufficient to meet the needs of residents.</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/approval completed prior to entry that identifies the level of care required. The nurse manager or clinical nurse leader screens all potential enquiries to ensure the service can meet the required level of care and specific needs of the resident.</p> <p>Residents (four rest home and three hospital including a resident funded by ACC) and relative 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 in accordance with the Medicines Care Guide for Residential Aged Care 2011. Registered nurses, enrolled nurse and senior caregivers responsible for the administration of medications have completed annual medication competencies and attended medication education. Registered nurses have completed syringe driver training. The service has fortnightly robotic rolls delivered which are checked by the RN against the medication chart. Any discrepancies are fed back to the supplying pharmacy. The service uses an electronic medication system. The clinical nurse leader conducts weekly monitoring of the administration of medication documentation and use of 'as required' medications. There were no residents self-medicating on the day of audit. The medication fridge is monitored for temperature at least weekly. All eyedrops had been dated on opening.</p> <p>Fourteen resident medication charts on the electronic medication system were reviewed (eight rest home and six hospital). The charts had photograph identification and allergy status recorded. Staff recorded the time and date of 'as required' medications. The effectiveness of 'as required' medication was recorded on the electronic system.</p> <p>All fourteen medication charts reviewed identified that the GP had reviewed the medication chart three-monthly.</p>

<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>A contracted company provides meals on-site. The service has an A grade council certificate. There is an eight-week seasonal and rotating menu approved by the dietitian. The menu includes resident preferences. The chef manager (interviewed) is notified of any changes to resident's dietary requirements. Resident likes/dislikes and preferences are known and accommodated with alternative meal options. A weekly resident's choice is included on the menu. Food is delivered in hot boxes to the dining room kitchenette where meals are served from the bain marie. Special requests and alternative meals are plated and labelled. Texture modified meals, fortified foods, protein drinks, dairy free and diabetic desserts are provided. The cook receives a dietary profile for each resident.</p> <p>The facility fridges, chiller and freezer have temperatures recorded at least daily. End cooked food temperatures and serving temperatures are recorded for each meal. All foods are stored correctly and date labelled. Cleaning schedules are maintained. Chemicals are stored safely within the kitchen. Staff were observed wearing correct personal protective clothing when entering the kitchen. The chemical provider completes a functional test on the dishwasher monthly.</p> <p>Staff working in the kitchen have food handling certificates and chemical safety training.</p> <p>Residents commented positively on the meals provided. The chef manager serves meals in the care centre and receives direct feedback from residents on meals. Resident meetings and surveys identify areas of improvement. The chef receives feedback from meetings and surveys.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>The reason for declining service entry to residents should this occur is communicated to the resident or family/whānau and they are referred to the original referral agent for further information.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely</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. Outcomes of risk assessment tools are used to identify the needs, supports and interventions required to meet resident goals. The interRAI assessment tool has been utilised for all residents and used routinely as part of the six-monthly care plan review.</p>

manner.		
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Resident-centred care plans describe the individual support and interventions required to meet the resident goals (link 1.3.6.1). The care plans reflect the outcomes of risk assessment tools. Care plans demonstrate service integration and include input from allied health practitioners.</p> <p>Short-term care plans were in use for changes in health status. These are evaluated regularly and either resolved within three weeks 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/relative 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>	PA Low	<p>When a resident's condition changes, the RN initiates a review and if required a GP or nurse specialist consultation. The relatives interviewed stated their family member'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 state their needs are being met.</p> <p>Adequate dressing supplies were sighted. Initial wound assessments with ongoing wound evaluations and treatment plans were in place for residents with wounds (skin tears, one chronic wound and five pressure injuries). Evaluation comments were documented at each dressing change to monitor the healing progress. The RN and nurse manager confirmed there is a wound nurse specialist available who has been involved in pressure injury management.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management and continence products identified for day use, night use and other management. Specialist continence advice is available as needed.</p> <p>There are a number of monitoring forms and charts available for use including (but not limited to): pain monitoring, restraint, blood sugar levels, weight, wound evaluations, food and fluid intake, repositioning charts and neurological observations. RNs review the forms/charts and completed risk assessments for any changes to health status. Not all interventions have been documented for changes to health.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity</p>	CI	<p>The service employs two diversional therapists in training (DT) to provide an activity programme across seven days for the rest home and hospital level of care residents. The activity team attend Summerset training sessions and the regional DT group. Both activity persons have current first aid certificates.</p> <p>The programme is planned a month in advance and has the flexibility to add other activities of interest or suggestions made by residents. Activities meet the recreational needs of both resident groups ensuring all</p>

<p>requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>residents have the opportunity for outings into the community. Other activities include a variety of exercises, newspaper reading, housie, bowls, reminiscing, crafts and happy hours. Community visitors include weekly entertainers, church services, volunteers and the dog squad. The DTs (in training) ensure daily contact is made with residents who choose to stay in their rooms and for those residents in serviced apartments. Specific individual activities are provided for the younger people within the care centre. The service is registered with a volunteer organisation. Care centre residents are invited to participate in village activities and village residents visit the care centre include piano players and the ukulele group.</p> <p>Residents are encouraged to maintain their former community links. Church services are held in the family/whānau room. The service has a wheelchair van for the rest home and hospital resident outings.</p> <p>Monthly meetings provide an opportunity for residents to feedback on the programme. The activity surveys have evidenced increased satisfaction with the activity programme.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>There is evidence of resident and family involvement in the review of resident centred care plans. All initial care plans reviewed had been evaluated by the registered nurses within three weeks of admission. Written evaluations were completed six-monthly or earlier for resident health changes in all files reviewed. There is evidence of multidisciplinary (MDT) team involvement in the reviews including input from the GP and any allied health professionals involved in the 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) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<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>
<p>Standard 1.4.1: Management Of Waste And</p>	<p>FA</p>	<p>Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Safety data sheets were readily accessible for staff. Chemicals</p>

<p>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>		<p>were stored safely throughout the facility. Personal protective clothing was available for staff and seen to be worn by staff when carrying out their duties on the day of audit. Relevant staff have completed chemical safety training.</p>
<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>	<p>FA</p>	<p>The building has a current building warrant of fitness that expires on 5 May 2017. Building has three levels with serviced apartments on the ground floor, care centre on the first floor and independent apartments on the second level. The service has reconfigured a sun lounge into a large palliative care suite with a kitchenette, open plan bedroom and lounge area and large full ensuite. There is a full-time maintenance person who oversees the property and gardening team and is available on call for facility matters. A 52-week planned maintenance schedule includes equipment checks, testing and tagging of electrical equipment and calibration of medical equipment. There is a system in place to report maintenance and repair requests. Hot water temperatures have been tested and recorded monthly with readings maintained below 45 degrees celsius. Preferred contractors for essential services are available 24/7.</p> <p>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 with seating and shade. The external areas are well maintained.</p> <p>The caregivers and registered nurses (interviewed) state they have all the equipment required to safely provide the care documented in the care plans.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with</p>	<p>FA</p>	<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 resident rooms have an ensuite and six other rooms have a shared ensuite. The palliative care room ensuite is large with enough room to use a shower trolley if required. 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>

personal hygiene requirements.		
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>There is adequate room to safely manoeuvre mobility aids and transferring equipment such as hoists in the resident bedrooms. The doors are wide enough for ambulance trolley access. Residents and families are encouraged to personalise their rooms, as viewed on the day of audit. The palliative care suite includes a kitchenette and lounge area for family/whānau use.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Communal areas within the care centre 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. The spacious dining room has a separate conservatory room off the dining area. There are separate balconies for resident use. There are seating alcoves within the facility. The communal areas are easily accessible for residents.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. All linen and personal clothing is laundered on-site. The laundry is located in the basement with shutes used for the delivery of dirty laundry. The laundry is well equipped and all machinery has been serviced regularly. There is personal protective equipment available. The laundry has defined clean/dirty areas.</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</p>	FA	<p>There are emergency and civil defence plans to guide staff in managing emergencies and disasters. Emergencies, first aid and cardiopulmonary resuscitation is included in the mandatory in-service programme. There is a first aid trained staff member on every shift. Summerset Bishopscourt has an approved fire evacuation plan and fire drills occur six-monthly. The kitchen has electric and gas cooking facilities and there are barbeques available in the event of power failure. There are two civil defence supplies on each level of</p>

<p>response during emergency and security situations.</p>		<p>the building. There are sufficient food supplies and water tanks hold enough water for use in a civil defence emergency. Call bells were evident in resident's rooms, lounge areas and toilets/bathrooms. The newly reconfigured palliative care suite has calls bells in the bedroom, lounge and ensuite. 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>	<p>FA</p>	<p>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.</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>	<p>FA</p>	<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 has a signed job description. The infection control programme is linked into the quality management system and reviewed annually at head office in consultation with infection control officers. The facility meetings include a discussion of infection control matters.</p> <p>Visitors are asked not to visit if they are unwell. Influenza vaccines are offered to residents and staff.</p> <p>Bishops court experienced two gastro outbreaks in August and November 2016. Notifications to public health and SDHB and appropriate documentation including infection log, education sessions for staff, meeting minutes and an outbreak debrief were sighted for each event.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the</p>	<p>FA</p>	<p>The infection control officer attends an annual Somerset training day for infection control officers. The infection control officer also attended external training. The infection control committee includes a representative from each department. The infection control committee meets quarterly and infection events are forwarded to head office for benchmarking.</p> <p>The facility has access to an infection control nurse specialist at the DHB, external infection control consultant, public health, laboratory, GP's and expertise within the organisation.</p>

organisation.		
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>There are comprehensive infection control policies that are current and reflected the Infection Control Standard SNZ HB 8134:2008, legislation and good practice. These are across the Summerset organisation and were reviewed last in September 2016. 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>	FA	<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 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 specified in the infection control programme.</p>	FA	<p>The infection control policy includes a surveillance policy including a surveillance procedure, process for detection of infection, infections under surveillance, outbreaks and quality and risk management. Infection events are collected monthly and entered onto the SWAY electronic system. The infection control officer provides infection control data, trends and relevant information to the infection control committee and clinical/quality meetings. Areas for improvement are identified and corrective actions are developed and followed up. The facility is benchmarked against other Summerset facilities of similar size and benchmarking results are fed back to the infection control officer and used to identify areas for improvement. Infection control audits are completed and corrective actions are signed off (sighted). Surveillance results are used to identify infection control activities and education needs within the facility.</p> <p>The service has evidenced improved outcomes for residents with the rate for UTIs remaining under the</p>

		national benchmarking rate for eleven months.
<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. There were no residents requiring the use of a restraint or an enabler at the time of audit. Staff receive training around restraint minimisation that includes annual competency assessments.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Low	Allied health professionals are involved in the care of the resident including the GP and podiatrist. Not all changes to resident's health (as described by the health professionals) have interventions for short term needs/supports. Neurological observations are commenced following unwitnessed falls, however, not all have been completed as per policy.	<p>1)Interventions had not been documented for a) one rest home resident with a skin condition identified by the podiatrist, b) a rest home resident in serviced apartment with knee pain and swelling as per GP notes, c) another rest home resident with increasing pain requiring analgesia as per GP notes and d) one hospital resident with a new episode of shoulder pain as per GP notes.</p> <p>2) Seven accident/incident forms reviewed for unwitnessed falls did not have neurological observations completed as per policy.</p>	<p>1)Ensure changes to health as identified by health professionals have interventions documented to meet the resident's needs/supports. 2) Ensure neurological observations are completed as per policy.</p> <p>90 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	CI	<p>Following the survey in 2015 the service identified an opportunity to improve the activities offered and increase resident participation in the development of the activity programme.</p>	<p>The DTs in training developed an action plan to identify activities of interest to the residents and involve them in the development of the plan. Resident representatives met with the DT in training to regularly review the activities offered and provide suggestions and frequency of activities on behalf of residents (resident recreational meeting minutes sighted). A variety of activities were introduced including a gardening club, planting a collection of native flaxes, community links with the marae and school both closely located to the facility, increase in van trips/outings and a men’s group with activities such as home brewing. 1) The gardening club meets in the conservatory room where plants are displayed. There has been a focus on sensory planting for smell, tastes (eg. herbs) and colour. Handmade driftwood sculptures hang from the ceiling. A gardening calendar is maintained by the garden group. 2) Native plants and flaxes have been purchased form a well-known collection and the service is supporting a community project to attract native birds to the area. The flaxes also provide flax for weaving for one of its Māori residents. 3) The residents have developed a close relationship with the school children next door who visit regularly to entertain and read to the residents. There is gate access between the facility and the school to facilitate regular visits.</p>

			The DT in training completes six-monthly internal activity surveys to monitor resident satisfaction. The results of the January 2017 survey were fed back with an overall result from 84-100%. Activities satisfaction improved from 3.9 in 2015 to 4.5 in October 2016 (with 5 being the highest). The service has been successful in improving resident satisfaction and participation in activities.
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	The service provides an environment that encourages good practice beyond the expected full attainment. The service has conducted quality improvement projects to support Summerset “do no harm” component as part of its commitment to improving resident care. A review process has occurred, including analysis and reporting of findings has occurred. There is evidence of action taken based on findings that has made improvements to service provision and resident care and reduced the number of urinary tract infections (UTIs).	In February 2016, national clinical indicator results noted an increase in UTIs above the agreed target range. This trend was also identified at Bishopscourt care centre. A project plan was implemented that included a range of initiatives including (but not limited to): a) increased fluid rounds, b) offering jelly, yoghurt, ice blocks and alternative fluid choices to residents having poor oral intake, c) increasing frequency of toileting and d) vulnerable residents encouraged with fluids and commenced on hydration charts. The service has been successful in reducing the number of UTIs per 1000 bed days in February 2016 from 1.71 to 1.18 per 1000 bed days in December 2016. The UTI rate per month remains under the benchmarking level for the last eleven months.

End of the report.