

Summerset Care Limited - Summerset in the Vines

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Summerset Care Limited
Premises audited:	Summerset in the Vines
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 22 January 2018 End date: 22 January 2018
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	40

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 in the Vines provides rest home and hospital (geriatric and medical) level of care for up to 43 residents. On the day of the audit, there were 40 residents.

This unannounced surveillance audit was conducted against a subset of the Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of resident's and staff files, observations and interviews with residents, relatives, staff and management.

The village manager is appropriately qualified and experienced and is supported by a recently employed care centre manager. The care centre manager is supported by a clinical nurse leader.

The service has addressed all three findings from their previous certification audit in relation to, care planning, activity plans and medication documentation.

This audit has identified one improvement required around internal audits.

The service is commented for maintaining their continued improvement rating around infection surveillance activities.

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.

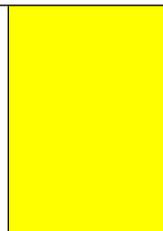


Standards applicable to this service fully attained.

Residents and family are well informed including of changes in resident's health. Management have an open-door policy. Complaints and concerns have been managed and a complaints register is maintained.

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.

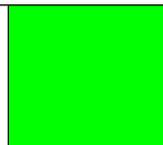


Some standards applicable to this service partially attained and of low risk.

The quality and risk management programme includes service philosophy, goals and a quality planner. Meetings are held to discuss quality and risk management processes. There is a health and safety management programme available to guide staff. Residents/family meetings held monthly. Incidents and accidents are reported. There are human resources policies to support recruitment practices. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. An education and training programme for 2018 is in place. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.



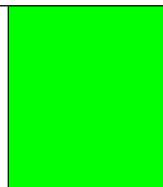
Standards applicable to this service fully attained.

Registered nurses are responsible for the provision of care and documentation at every stage of service delivery. The residents and family interviewed confirmed their input into care planning. A sampling of residents' clinical files validated the service delivery to the residents. Where progress is different from expected, the service responds by initiating changes to the care plan or recording the changes on a short-term care plan. There is an appropriate medicine management system in place.

Planned activities are appropriate to the group setting. The residents and family interviewed confirmed satisfaction with the activities programme. Individual activities are provided either within group settings or on a one-on-one basis. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met where required. There is a well-equipped kitchen. Provision of the food service is provided by an external company.

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.

The building has a current warrant of fitness.

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.

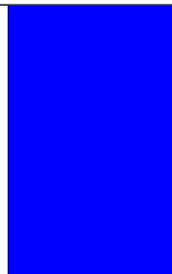


Standards applicable to this service fully attained.

Restraint minimisation and safe practice policies are in place to guide staff in the use of an approved enabler and/or restraint. On the day of audit, there were seven residents with restraint and one using enablers. Staff training has been provided around restraint minimisation and management of challenging behaviours. Staff training has been provided around restraint minimisation and management of challenging behaviours.

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.



All standards applicable to this service fully attained with some standards exceeded.

Summerset in the Vines has an infection control programme that complies with current best practice. The infection control programme is designed to link to the quality and risk management system. Records of all infections are kept and provided to head office for benchmarking.

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	14	0	1	0	0	0
Criteria	1	38	0	1	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a complaints policy that describes the management of the complaints process. Information about complaints is provided on admission to residents and their families/whānau. Feedback forms are available for residents and families/whānau in various places around the facility. All staff interviewed were able to describe the process around reporting complaints. There is a complaint's register. Five complaints have been made since the last audit. All complaints reviewed had written investigations, timeframes and where required, corrective actions were documented and implemented. Results and outcomes of the investigations are fed back to complainants. Discussions with residents confirmed that any issues are addressed, and they feel comfortable to bring up any concerns.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective</p>	FA	<p>Five residents (two hospital and three rest home) interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. Accident/incidents, complaints procedures and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident. Ten incidents/accident forms reviewed include a section to record family notification. All forms evidenced family were informed or if family did not wish to be informed. Two relatives (hospital) interviewed confirmed that they are notified of any changes in their family member's health status. An interpreter policy and contact details of interpreters is available. Interpreter services are used where indicated.</p>

communication.		
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Summerset in the Vines provides care for up to 43 residents at hospital and rest home level care. On the day of the audit, there were 42 residents in total, 20 residents at rest home level (two were currently in hospital), including two residents on a mental health contract and 20 residents at hospital level. All other residents were under the aged residential related care (ARRC) contract. All beds are identified as dual-purpose.</p> <p>The Summerset Group Limited Board of Directors have overall financial and governance responsibility and there is a company strategic business plan in place. Summerset in the Vines has a site-specific business plan and goals that is developed in consultation with the village manager, clinical nurse manager and regional operations manager. The 2018 business plan was being finalised at the end of January 2018. There is a full evaluation at the end of the year. The 2017 evaluation was sighted.</p> <p>The village manager (non-clinical) has been in the role for one year and has been with Summerset in the Vines for two years prior. The village manager is supported by a care centre manager and a clinical nurse lead. The care centre manager has been in the position since December 2017 and has considerable background in the health industry (including DHB and aged care). The clinical nurse lead has been in the role for one and a half years and has been with Summerset for ten years. There is a regional operations manager and regional quality manager who are available to support the facility and staff.</p> <p>The village manager has attended at least eight hours of leadership professional development relevant to the role.</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>	PA Low	<p>There is a documented Summerset organisation's quality and risk management system. The content of the policies and procedures is detailed to allow effective implementation by staff. The service's policies are reviewed at an organisational level. The quality and risk management system is designed to monitor contractual and standards compliance. The Summerset group has a 'clinical audit, training and compliance' calendar. The calendar schedules the training and audit requirements for the month and the village manager completes a 'best practice' sheet confirming completion of these requirements. The best practice sheet reports (but not limited to): meetings held, induction/orientation, audits, competencies and projects. This is forwarded to head office as part of the ongoing monitoring programme.</p> <p>The service is implementing the organisations internal audit programme. However corrective action plans were not always completed and signed off for internal audits that were not compliant. There are monthly accident/incident benchmarking reports completed by the care centre manager that break down the data collected across the rest home, hospital and staff incidents/accidents. Infection control is also included as part of benchmarking across the organisation. Annual resident/relative satisfaction surveys are completed with results communicated to residents and staff. The overall service result for the resident/relative satisfaction survey completed in September 2017 was at 99%.</p>

		<p>Summerset's clinical quality manager analyses data collected via the monthly reports and corrective actions are required based on benchmarking outcomes. Summerset has a data tool "Sway- the Summerset 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. A caregiver is the health and safety officer (interviewed) and had completed the specific health and safety training requirements. Health and safety internal audits are completed. There is a meeting schedule including monthly quality improvement and staff meetings that includes discussion about clinical indicators (e.g., incident trends, infection rates and health and safety). Registered nurse/clinical meetings are held monthly.</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>Individual reports are completed for each incident/accident with immediate action noted and any follow-up action(s) required. Ten accident/incident forms were reviewed for January 2018. Each event involving a resident reflected a clinical assessment and follow-up by a registered nurse (RN). Data collected on incident and accident forms are linked to the quality management system. Discussions with the village manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Advised there have been no events since the last audit that would have triggered a section 31 notification. The appointment of the care centre manager has been notified to HealthCERT.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are human resources policies to support recruitment practices. Five staff files reviewed, including one clinical nurse lead, two RN's and two caregivers evidenced employment contracts and completed orientation. A register of registered nursing staff and other health practitioner practising certificates is maintained. Recruitment, qualifications, orientation training, performance management information is available on-site for staff. The orientation programme includes documented competencies and induction checklists.</p> <p>There is an annual education plan for 2018 that is outlined on the 'clinical audit, training and compliance calendar'. In 2017, the education plan had been completed and further training had been provided to caregivers around assessments and RNs around care planning and assessments. Core competencies are completed, and a record of completion is maintained on staff files, as well as being scanned into 'Sway' (sighted). The service has # of six RNs trained in interRAI.</p>
Standard 1.2.8: Service	FA	<p>There is a safe staffing policy and procedure, which describes staffing and is based on benchmarking information.</p>

<p>Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>There are clear guidelines for increase in staffing depending on acuity of residents. The village manager and care home manager lead both work 40 hours per week from Monday to Friday and are available on call for any emergency issues or clinical support.</p> <p>The clinical nurse lead works 40 hours per week from Thursday to Monday. The service provides 24-hour RN cover. There is one RN and six caregivers on duty in the morning shift, one RN and five caregivers on duty in the afternoon shift and one RN, and two caregivers on duty in the night shift. A staff availability list ensures that staff sickness and vacant shifts are covered. Five caregivers interviewed confirmed that staff are replaced. Staffing levels and skills mix policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<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. RNs and ENs are responsible for the administration of medications in the rest home/hospital care centre. Senior care assistant's complete competencies for the checking and witnessing of medications as required. Medication competencies and education has been completed annually. All medications delivered were evidenced to be checked on delivery with any discrepancies fed back to the supplying pharmacy. The service has an electronic medication system. There were no residents self-medicating on the day of audit.</p> <p>Ten resident medication charts on the electronic medication system were reviewed. The charts had photograph identification and allergy status recorded. Indications for use were documented in all charts reviewed. Dietary supplements were charted where used. This is an improvement on previous audit.</p> <p>All 10 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>	FA	<p>Compass is contracted for the provision of meals on-site. There is an eight-week rotating menu approved by the dietitian. The chef manager is supported by a weekend cook and team of kitchen hands. Resident likes/dislikes and preferences are known and accommodated with alternative meal options. The kitchen is adjacent to the dining room. Meals are served from the bain marie to residents in the dining room. The cook receives a dietary profile for each resident and these are updated as required.</p> <p>The chiller and freezers have daily temperatures recorded. End cooked food temperatures are recorded twice daily. All foods are stored correctly, and date labelled. Cleaning schedules are maintained. Chemicals are stored safely within the kitchen. There is a HACCAP programme in place with a validated food control plan.</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 attends the resident meetings and</p>

		welcomes feedback on the meal service.
<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>	FA	<p>When a resident's condition alters, the registered nurse initiates a review and if required a GP visit or nurse specialist consultant. There is documented evidence where care plans have been updated to reflect the changes in resident needs/supports. Short term care plans are developed for infections and acute changes.</p> <p>Five resident files reviewed included interventions to support residents current assessed needs. One resident on insulin had a diabetic management plan, two residents with weight loss had interventions documented. There was a clear link between GP notes, allied health notes and the current care plan. This is an improvement on previous audit.</p> <p>Monitoring forms in place include (but are not limited to); monthly weight, blood pressure and pulse, food and fluid charts and blood sugar levels. Progress notes document changes in health and significant events. Residents and relatives confirm their expectations are met and they are kept informed of any changes to health.</p> <p>A sample of 10 wounds were reviewed during the audit including (two grade 1 PIs three grade 2 PIs, one chronic ulcer, one surgical incision and three skin tears). All wounds included a wound assessment and treatment plan and regular evaluations have been completed. The RNs have access to specialist nursing wound care management advice if required. Adequate dressing supplies were sighted in the treatment rooms.</p> <p>Continence products are available and resident files include a three-day urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the RNs interviewed.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The service employs a recreational therapist (31 hours per week. Sunday to Thursday). There is also a part time recreational therapist on Friday and Saturday. The programme provides activities that are meaningful and relevant for all residents. Time is spent with residents and families to further explore their individual life goals and to aid development of new and meaningful activities. Rest home and hospital residents join together for the activity programme. Participation of residents is monitored and documented. There are strong links with community. Group activities reflect ordinary patterns of life and include at least weekly planned visits to the community. All residents in the facility may choose to attend any of the activities offered. Daily contact is made, and one-on-one time is spent with residents who are unable to participate in group activities or choose not to be involved in the activity programme. There is a weekly exercise programme.</p> <p>The recreational therapist teleconferences with other Summerset recreational therapists weekly.</p> <p>There are regular van outings for residents (as appropriate), regular entertainment and involvement in community. The activity programme is developed two months in advance and a calendar is displayed throughout the facility.</p>

		The activity plans reviewed were well documented and reflected the resident's preferred activities and interests. Each resident has an individual activities assessment on admission and from this information, an individual activity care plan is developed. This is an improvement on the previous audit. The activities plans were reviewed six-monthly. Residents and families interviewed stated they enjoy the variety of activities offered and they have input into planning of the programme via daily feedback, resident surveys and at resident meetings.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Care plans reviewed had been evaluated by RNs six-monthly, or when changes to care occurred. Written evaluations describe the resident's progress against the resident's (as appropriate) identified goals. Care plans for short-term needs were evaluated and either resolved or added to the long-term care plan as an ongoing problem. The GP reviews residents at least three-monthly or when there is a change in health status. The family members interviewed confirmed they are invited to attend the GP visits and multidisciplinary care plan reviews.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building has a current building warrant of fitness which expires on 24 February 2018. There is an implemented preventative and reactive maintenance plan.
Standard 3.5: Surveillance 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 surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control officer uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the general practitioners and laboratory that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility. Surveillance data is available to all staff. Infections statistics are included for benchmarking. Corrective actions are established where infections are above the benchmark. All infections are documented monthly in an infection control register.
Standard 2.1.1:	FA	The policies and procedures include definitions, processes and use of restraints and enablers. On the day of

Restraint minimisation Services demonstrate that the use of restraint is actively minimised.		audit, there were seven residents with restraint and one using enablers. Staff training has been provided around restraint minimisation and management of challenging behaviours. Restraint audit last completed December 2017 – 99.2%.
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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 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	The organisation has a quality management system in place that schedules the internal audits and monitoring required. Corrective action plans were not always completed and signed off for internal audits that were not compliant.	There is an internal audit schedule calendar in place. Sixteen of eighteen corrective action plans were not completed and signed off for internal audits not compliant.	<p>Ensure that any corrective action plans required for any internal audits that are not compliant are completed and signed off.</p> <p>90 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 3.5.7</p> <p>Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>	CI	<p>The infection control officer provides infection control data, trends and relevant information to the infection control committee and clinical/quality meetings. Areas for improvement are identified, corrective actions developed and followed-up. The service continues to implement projects related to infection prevention.</p>	<p>The achievement of the rating that service provides an environment that evaluates infection surveillance and makes recommendations continues to be beyond the expected full attainment. The service has conducted a number of quality improvement projects where 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. The projects include reviewing if the improvements have had positive impacts on resident safety. Example A norovirus outbreak in November that involved 62% of residents and 42% of staff. Outbreak management plan was followed, and an outbreak review was completed. As a result of the review, corrective actions were initiatives and outbreak bins were implemented.</p>

End of the report.