

Summerset Care Limited - Summerset on the Coast

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Summerset Care Limited
Premises audited:	Summerset on the Coast
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 7 February 2019 End date: 8 February 2019
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:	44

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Summerset on the Coast provides rest home and hospital level care for up to 44 residents and on the day of the audit there were 44 residents. The service is managed by a manager (a relieving manager was onsite) and a care centre manager. The residents and relatives interviewed spoke positively about the care and support provided.

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

The service has addressed the shortfall from the previous certification audit around care planning interventions.

There are no further areas identified at this surveillance audit that require improvement.

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 families are kept informed. Residents and their family/whanau are provided with information on the complaints process on admission. Complaints are being managed in a timely manner. Staff are aware of the complaints process and to whom they should direct complaints.

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.
---	--	--

Services are planned, coordinated, and are appropriate to the needs of the residents. A manager and care centre manager/registered nurse are responsible for the day-to-day operations of the facility. Quality and risk management processes are maintained, reflecting the principals of continuous quality improvement. Quality goals are documented for the service. Corrective action plans are implemented where opportunities for improvement are identified. A risk management programme is in place, which includes a risk management plan, incident and accident reporting, and health and safety processes. Adverse, unplanned and untoward events are documented by staff.

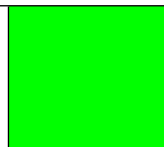
Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice, meeting legislative requirements. An orientation programme is in place for new staff. On-going education and training for staff is in place.

Registered nursing cover is provided 24 hours a day, seven days a week. There are adequate numbers of staff on duty to ensure residents are safe.

The residents' files are appropriate to the service type.

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.

Assessments (including interRAI), resident centred care plans and evaluations were completed by the registered nurses within the required timeframes. Risk assessment tools and monitoring forms were available and implemented. Resident centred care plans are individualised.

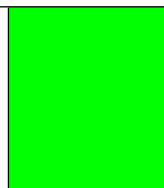
Recreational therapists develop and provide a seven day week activity programme. Community links are maintained. There is volunteer involvement and visiting entertainers.

There is an electronic medication system that meets legislative requirements. Staff responsible for the administration of medications complete annual medication competencies and education.

The food service is inhouse. Resident's individual dietary needs are identified and accommodated. Staff have attended food safety and hygiene training. Additional snacks are available after hours.

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.

A current building warrant of fitness expiring 1 February 2020.

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.
---	--	--

Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. The service currently has six residents assessed as requiring the use of restraint and one requiring an enabler.

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 and its content and detail is appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator (enrolled nurse) has defined responsibilities for the monitoring of infections. Surveillance activities include audits of the facility, hand hygiene and surveillance of infection control events and infections. Staff receive on-going training on infection control.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	17	0	0	0	0	0
Criteria	0	43	0	0	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. Complaints forms are available. Information about complaints is provided on admission. Interviews with three residents (two rest home level and one hospital level) and family members confirmed their understanding of the complaints process. Staff interviewed (two caregivers, five registered nurses (RN), two enrolled nurses (EN), one diversional therapist) were able to describe the process around reporting complaints.</p> <p>There is an electronic complaints register that includes verbal and written complaints and evidence to confirm that complaints are being managed in a timely manner including acknowledgement, investigation, time lines, and corrective actions when required and resolutions. From February 2018 to Jan 2019 there had been three complaints with evidence of follow-up and feedback to staff meetings. Complainants are provided with information on how to access advocacy services through the Health and Disability Commissioner if resolution is not to their satisfaction.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively</p>	FA	<p>An open disclosure policy describes ways that information is provided to residents and families. The admission pack gives a comprehensive range of information regarding the scope of service provided to the resident and their family on entry to the service and any items they are to pay for that are not covered by the agreement. Regular contact is maintained with family including if an incident or care/ health issues arises. Three family members interviewed (all hospital level relatives) stated they were well informed. Ten incident/accident forms</p>

<p>with consumers and provide an environment conducive to effective communication.</p>		<p>were reviewed and nine identified that the next of kin were contacted. The tenth was for a resident who requested family not be notified.</p> <p>There are three monthly resident's meetings chaired by a resident advocate where any issues or concerns to residents are able to be discussed. Minutes are maintained and show follow-up actions for resolution of matters raised.</p> <p>The service has policies and procedures available for access to DHB interpreter services and residents. The information pack is available in large print and can be read to residents.</p> <p>Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Summerset on the Coast provides rest home and hospital level care for up to 44 residents. The rooms are approved for both rest home or hospital level residents (all are dual purpose). On the day of the audit there were 44 residents - 9 rest home level and 35 hospital level. There is a retirement village attached (with no certified apartments) as part of the complex with overall management of the site provided by a relieving village manager who had been employed at Summerset for thirteen years and a property manager.</p> <p>A strategic plan is in place for the organisation. An annual quality plan for the service is linked to the strategic plan and includes annual goals and objectives. Quality is overseen by the organisation's clinical quality manager.</p> <p>The manager has been employed by Summerset for a number of years and was on secondment duty on the days of audit. An experienced Summerset manager was relieving for six months. There is a care centre manager(RN) who has been two years in the role and is assisted by a clinical nurse leader(RN) who has been at the facility for 3.5 years.</p> <p>The village manager and care centre manager have maintained greater than eight hours of professional development activities related to managing an aged care facility</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and</p>	<p>FA</p>	<p>A quality and risk management plan is in place. Policies and procedures reflect evidence of regular reviews as per the document control schedule. New and/or revised policies are made available for staff to read and sign that they have read and understand the changes. Village managers and nurse managers are held accountable for their implementation.</p> <p>The monthly collating of quality and risk data includes (but is not limited to) residents' falls, infection rates, and pressure areas. Data is collated and benchmarked against other Summerset facilities to identify trends. A resident satisfaction survey is conducted each year. Results for 2018 reflect resident satisfaction with the</p>

<p>risk management system that reflects continuous quality improvement principles.</p>		<p>services received. An annual internal audit schedule was sighted for the service. Corrective actions are developed where opportunities for improvements are identified and are signed off by the village manager when completed. Staff are kept informed of audit findings and quality initiatives.</p> <p>A falls reduction plan was sighted for the service. Falls prevention strategies are in place that include the identification of interventions on a case-by-case basis to minimise future falls. Sensor mats and physiotherapy services are utilised.</p> <p>There is a health and safety team who meet monthly. Data relating to health and safety is entered into the electronic Risk Management Support System (RMSS). This is overseen by the organisations operation manager for the area who approves when risks have been closed off. Hazard identification forms and a hazard register are in place.</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>	<p>FA</p>	<p>The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident (events) information. The reporting system is integrated into the quality and risk management programme. Ten (of 15 events for the month of December 2018) were sampled. Once incidents and accidents (events) are reported the immediate actions taken are documented on RMSS. All ten events sampled evidenced clinical follow up. The incidents are then reviewed and investigated by the manager. If risks are identified these are processed as hazards.</p> <p>Discussions with the manager and care centre manager have confirmed their awareness of statutory requirements in relation to essential notification. There had been nil notifications since the previous audit.</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>	<p>FA</p>	<p>There are job descriptions available for all relevant positions that describe staff roles, responsibilities and accountabilities. The practising certificates of nurses are current. The service also maintains copies of other visiting practitioners practising certificates including GP, pharmacist and physiotherapist. Five staff files were reviewed (one caregiver, one chef, one diversional therapist, one registered nurse and the clinical nurse leader). Evidence of signed employment contracts, job descriptions, orientation, and training was available for sighting. Annual performance appraisals for staff have been conducted annually (one was not yet due). Newly appointed staff complete an orientation that is specific to their job duties. Interviews with two caregivers described the orientation programme that includes a period of supervision.</p> <p>The service has a training policy and schedule for in-service education. The in-service schedule is implemented, and attendance is recorded. For those staff members who are unable to attend education, a competency is completed.</p>

		There are implemented competencies for registered nurses including (but not limited to); medication, restraint, syringe driver and insulin administration.
<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>	FA	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. Two RNs or an RN and an EN are on duty 7am to 11pm with one rostered overnight, seven days a week. On morning shift, there are 7 carers on (3 working shorter duties), on afternoon shift there are six carers (four working shorter duties) and two carers on duty at night. Staff reported that staffing levels and the skill mix was appropriate and safe. All families interviewed advised that they felt there was sufficient staffing. The roster is changed in response to resident acuity and occupancy.</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>The service medication management system follows recognised standards and guidelines for safe medicine management practice. Medimap electronic charting system was introduced in 2018 and robotic packaging is used. RNs and enrolled nurses are responsible for the administration of medications in the rest home and hospital wings. Annual medication competencies are completed (caregivers undertake competency for checking only at night when one RN is on). All incoming medications are checked against the medication charts. There are no standing orders. One resident is self-medicating and all aspects of checking, competency and safe storage are being met. The medication fridge temperature is recorded daily. Emergency equipment is checked weekly.</p> <p>Ten resident medication charts sampled (three rest home and seven hospital) are identified with photographs and allergy status. The prescribing of regular and prn medications meets legislative requirements. The ten 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>All meals and baking is undertaken on site under the supervision of a chef and cook. There is a seasonal 4 weekly rotating menu approved by the dietician (July 2018). There are alternative meal options available and resident likes/dislikes and preferences are known and accommodated. Special diets include gluten free, lactose free, peanut free (allergy based) and pureed meals as assessed for residents by the RN. The chef receives a dietary profile for each resident.</p> <p>The kitchen is well equipped, and the fridges and freezers have daily temperatures recorded. End cooked food temperatures are recorded daily. Cleaning schedules are maintained. Chemicals are stored safely within the kitchen. Staff were observed wearing correct personal protective clothing.</p> <p>Staff working in the kitchen have food handling certificates and chemical safety training. A Food Control Plan</p>

		was registered in June 2018. The overall response to the food delivered by residents and relatives was very positive.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Resident centred care plans described in detail the individual support and interventions required to meet the residents' goals. The care plans reflect the outcomes of risk assessment tools. Care plans demonstrate service integration and include input from allied health practitioners. All five plans sampled (3 hospital and 2 rest home) evidenced appropriate interventions and updates to long-term care plans. Between the five residents, six short-term plans had been used recently to give accurate interventions for their changing conditions. The previous finding relating to resident's care plans including interventions to meet their current needs had been addressed.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Residents interviewed state their needs are being met. Relatives interviewed state their relative's needs are met and they are kept informed of any health changes, GP visits and care plan reviews. There is documented evidence of communication with families on the consultation record. When a resident's condition alters, the registered nurses initiate a review and if required, GP or specialist consultation. Dressing supplies are available, and a treatment room is stocked for use. Continence products are available, and residents' files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist advice available to nurses (but not limited to) includes continence advice, wound specialist advice, diabetic nurse advice. There were initial wound assessments, treatment plans and on-going evaluation in place for three skin tears, one chronic wound and five 'other' wounds such as lesions/excoriations. There were no pressure injuries.
Standard 1.3.7: Planned Activities 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.	FA	The service employs a diversional therapist and a recreational therapist to cover a seven-day week integrated rest home and hospital activity programme. The therapists have current first aid certificates. The programme is planned a month in advance and sent to head office for approval. It includes activities coordinated by the activity team, entertainers, themes and events, and musical therapy. Community links are maintained. Church services are held on-site. Daily contact is made with residents who are unable or choose not to participate in group activities (a number of examples of this were noted on audit). The service has a wheelchair van for outings. The activity assessment is completed in consultation with the family on admission and entered on Vcare. Monthly progress notes are written. Therapy plans sighted in resident files were individualised and reviewed six monthly. The recreational therapists are involved in the multi-disciplinary team (MDT) reviews. The feedback from three residents and three relatives was that there was a varied programme one could join in with or choose

		not to if that was one's wish.
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>There is evidence of resident and family involvement in the review of resident centred care plans. Written evaluations were completed in all files sampled. There is evidence of MDT involvement in the reviews. Short term care plans are evaluated by the RN every three days.</p> <p>All initial care plans are evaluated by the registered nurses within three weeks of admission.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	A current building warrant of fitness is posted in a visible location (expiry 1 February 2020).
<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>Infection monitoring is the responsibility of the infection control coordinator (enrolled nurse). The infection control policies were all reviewed in 2018 when the organisation moved to Bug Control and describe routine monthly infection surveillance and reporting. Monthly surveillance activities are appropriate to the acuity, risk and needs of the residents. There have been no outbreaks. Infection types and numbers are entered into the electronic database, which generates a monthly analysis of the data. The analysis is reported to the monthly infection control and staff meetings and the CCM makes available to all staff with staff meeting minutes. The data is benchmarked with other Summerset facilities and overseen by the head office infection coordinator also. Infection control is discussed at clinical meetings and staff handovers. Two infection control audits in January 2018 had 100% compliance.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint</p>	FA	<p>There are policies around restraints and enablers. The service currently has six residents assessed as requiring the use of restraint (bed rails and lap belts) and one requiring an enabler (bedrails only). Their care plans are up to date and provide the basis of factual information in assessing the risks of safety and the need for restraint. On-going consultation with the resident and family/whanau is also identified. Residents voluntarily request and consent to enabler use.</p>

is actively minimised.		Staff received training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers.
------------------------	--	---

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.

No data to display

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

No data to display

End of the report.