

Summerset Care Limited - Summerset on the Coast

Introduction

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

The audit has been conducted by BSI Group New Zealand Ltd, 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: 22 February 2021 End date: 23 February 2021
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:	36

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 on the Coast provides rest home and hospital (geriatric and medical) level care for up to 44 residents. On the day of the audit there were 36 residents.

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

The village manager is appropriately qualified and experienced and is supported by a care centre manager (registered nurse) who oversees the clinical services. There are quality systems and processes being implemented. Induction and in-service training programmes are in place to provide staff with appropriate knowledge and skills to deliver care. The residents and relatives interviewed spoke positively about the care and support provided.

There are four areas of continuous improvement awarded around good practice, prevention of falls, food services, and reducing the rate of urinary tract infections.

Consumer rights

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

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

The service functions in a way that complies with the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and related services are readily available to residents and families. Policies are available that support residents' rights. Cultural assessment is undertaken on admission and during the review process. Residents and family interviewed verified ongoing involvement with the community. Care plans accommodate the choices of residents and/or their family. Complaints processes are being addressed in line with HDC requirements.

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 on the Coast has an established quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to a number of meetings including (but not limited to) monthly quality improvement meetings. Annual surveys and regular resident meetings provide residents and families with opportunities for feedback about the service. Quality performance is reported to staff at meetings and includes discussions relating to incidents, infections and internal audit results. There are human resources policies that cover 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 with safe staffing levels implemented.

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.

The registered nurses are responsible for each stage of service provision. Residents' records reviewed provided evidence that the registered nurses utilise the interRAI assessment to assess, plan and evaluate care needs of the residents. These are then reviewed and discussed with the resident and/or family/whānau input. Care plans demonstrate service integration and were reviewed at least six-monthly. Resident files include medical notes by the contracted general practitioner (GP), and visiting allied health professionals.

All staff responsible for the administration of medicines complete education and medication competencies. The electronic medication charts have been reviewed both three-monthly by the general practitioner and monthly by the contracted pharmacist.

The recreation therapists implement the activity programme to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and themed celebrations. Residents and families reported satisfaction with the activities programme.

All meals are cooked on site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. There are nutritious snacks available at all times. The organisational dietitian reviews the Summerset menu plans.

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 holds a current building warrant of fitness. All internal and external areas are safe and well maintained. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Chemicals are stored securely throughout the facility. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances. Electrical equipment has been tested and tagged. All medical equipment and all hoists have been serviced and calibrated (where applicable). Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. Cleaning and laundry services are well monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies are provided. There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency. There is an approved evacuation scheme and emergency supplies for at least three days. At least one first aid trained staff member is on duty at all times.

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.
---	--	--

There are documented policies and procedures around restraint use and use of enablers. During the audit, there were two residents using restraint and one resident using an enabler. Staff training around the use of restraint and enablers is provided. Restraint is only used as a last resort.

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 are appropriate for the size, complexity and degree of risk associated with the service. The infection control officer is responsible for coordinating education and training for staff. The infection control coordinator has completed annual training provided by Summerset head office and online DHB training. There is a suite of infection control policies and guidelines available electronically to support practice. The infection control officer uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. The service engages in benchmarking with other Summerset facilities. There have been two norovirus outbreaks since the previous audit (January 2020 and February 2021) that were appropriately managed.

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	49	0	0	0	0	0
Criteria	4	97	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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Discussions with thirteen staff (four caregivers, four registered nurses (RNs), one enrolled nurse (EN), one recreational therapist, one chef, one property manager, one laundry) confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and its application to their job role and responsibilities. Five residents (two rest home and three hospital) and four relatives (hospital) were interviewed confirming the services being provided are in line with the Code. Observations during the audit also 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</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. Written general and specific consents were sighted in the six resident files reviewed (two rest home and four hospital). Caregivers and registered nurses (RNs) interviewed, confirmed verbal consent is obtained when delivering care.</p> <p>Resuscitation orders are 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) discusses resuscitation with families/enduring power of attorney (EPOA) where the resident is deemed incompetent to make a decision. Discussion with family members identifies that the service actively involves them in decisions that affect their relative's lives.</p> <p>Six resident files of long-term residents have signed admission agreements.</p>

consent.		
<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	<p>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> <p>The designated health advocate lives in the adjacent retirement village. They have a social work background and can tap into their knowledge and awareness of professional boundaries to ensure that a professional approach is undertaken. Positive outcomes since this individual accepted the advocate role have included greater opportunities to create community links between the retirement village and care centre, the instigation of the Village's men shed with monthly get togethers in the care centre, and empowering people from the retirement village to volunteer to support those in care who are identified as feeling lonely.</p>
<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	<p>Visitors were observed coming and going during the audit. Interviews with staff, residents and relatives confirmed residents are supported and encouraged to remain involved in the community and external groups. Relatives and friends are encouraged to be involved with the service and care. The service promotes community visitors to the village and encourage resident involvement. Community links are primarily within the village. Visitors to the facility include pet therapy and the chaplaincy service (eg, for grief and dying). Two religious denominations are actively involved with the facility (Catholic and Anglican).</p>
<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 readily available. Information about complaints is provided on admission. Interviews with residents and family members confirmed their understanding of the complaints process.</p> <p>There is an electronic complaint register that includes verbal and written complaints and evidence to confirm that complaints are being managed in a timely manner including acknowledgement, investigation, timelines, corrective actions (when required) and resolutions. In 2020 there were eight complaints received with evidence of robust follow-up actions taken and feedback provided in staff meetings including corrective actions (if any). No complaints have been received year to date (2021).</p> <p>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 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>The service provides information to residents that includes 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 confirmed that they were well informed about the Code. Informal, monthly resident meetings are held with the activities staff and the care centre manager, and three-monthly residents' meetings are held with the facility advocate. These meetings provide the opportunity for residents to raise concerns. An annual residents/relatives survey is completed.</p>
<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>	<p>FA</p>	<p>Care staff interviewed were able to describe the procedures for maintaining confidentiality of resident records, resident's privacy and dignity. House rules and a code of conduct are signed by staff at commencement of employment. Contact details of spiritual/religious advisors are available. Residents and relatives interviewed reported that residents are able to choose to engage in activities and access community resources. There is an elder abuse and neglect policy. Staff education and training on abuse and neglect last occurred in May and July 2020 with 41 attending.</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>	<p>FA</p>	<p>Summerset has a Māori health plan that includes a description of how they achieve the requirements set out in the contract. There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. At the time of the audit there were no residents that identified as Māori. Links are established with the Māori health unit for the Kapiti coast (Hora Te Pai Health Services). A local kaumātua was consulted on the current Māori health plan. Staff interviewed were able to describe how they can ensure they meet the cultural needs of residents.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive</p>	<p>FA</p>	<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 and values are further discussed and incorporated into the care plan. Six monthly multi-disciplinary team meetings occur to assess if needs are being met. Family are invited to attend. Discussion with family/whānau confirmed values and beliefs are considered. Residents interviewed confirmed that staff take into account their culture and values.</p>

culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.		
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Staff job descriptions include responsibilities and staff sign a copy on employment. The monthly quality improvement meetings include discussions on professional boundaries and concerns as they arise. Management provide guidelines and mentoring for specific situations. Interviews with managers and staff confirmed their awareness of professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	CI	<p>Residents and relatives interviewed spoke positively about the care and support provided. Staff have a sound understanding of principles of aged care and stated that they feel supported by the village manager and care centre manager. All Summerset facilities have a master copy of policies which have been developed in line with current accepted best practice and are reviewed regularly. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff.</p> <p>There is a quality improvement programme that includes performance monitoring against clinical indicators and benchmarking against like services within the Summerset group of aged care facilities. There is evidence of education being supported outside of the training plan. There are implemented competencies for caregivers and registered nurses including (but not limited to): insulin administration, medication, wound care and manual handling.</p> <p>Examples of quality initiatives implemented over the past year include a project addressing the ear health of residents and implementing a polypharmacy initiative. The service has continued to develop and enhance its processes to manage the resident's end stage of life, including supporting families and staff. Guidelines developed around the last few days of life, physical death, extended family support, and mental and spiritual health are in line with the DHB focus on palliative care (Te Ara Whakapiri). This is an area of continuous improvement.</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 issue arises. Family members</p>

<p>with consumers and provide an environment conducive to effective communication.</p>		<p>interviewed stated they were well informed. Ten incident/accident forms were reviewed, and all identified that the next of kin were contacted.</p> <p>There are three-monthly residents' 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. 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. On the day of the audit there were 36 residents - 11 rest home level and 25 hospital level. All residents were under the aged residential care contract (ARCC).</p> <p>There is a retirement village attached (with no certified apartments) as part of the complex with overall management of the site provided by a village manager who has been employed at Summerset for five years. The care centre is managed by a care centre manager (RN) who has been in her role for over five years. She is assisted by a clinical nurse leader (CNL).</p> <p>A 2021 quality and risk management plan is currently in draft format awaiting approval by head office. This plan is updated each year with evidence of regular review of the facility's goals and objectives throughout the year. Quality is overseen by the organisation's regional quality manager who was available during the audit.</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 1.2.2: 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</p>	<p>FA</p>	<p>During the temporary absence of the care centre manager, the CNL provides clinical leadership/oversight and the village manager is delegated operational responsibilities. The regional operations manager and the regional quality manager provide oversight and support.</p>

safe services to consumers.		
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>An annual quality and risk management plan is in place.</p> <p>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 care centre 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, bruising, skin tears and infection rates. Data is collated and benchmarked against other Summerset facilities to identify trends. A resident satisfaction survey is conducted each year. Results for 2020 reflect high levels of resident satisfaction with the 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 when completed. Staff are kept informed of audit findings and quality initiatives, evidenced in the range of meeting minutes (eg, staff, quality, RN, caregiver).</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. Falls have reduced over the past year and are below the Summerset benchmark resulting in a rating of continuous improvement.</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). Hazard identification forms and a hazard register are in place. A recent (external) health and safety audit conducted identified several (low risk) partial attainments. Corrective actions were being implemented at the time of the audit.</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>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 incident reports, held electronically, were sampled (six unwitnessed falls, one pressure injury, one challenging behaviour, two soft tissue injuries (skin tears)). All ten events sampled evidenced clinical follow-up. Adverse events are reviewed and investigated by the care centre 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. Section 31 notifications since the previous audit have included one suspected theft, two outbreaks, and one instance of an enrolled nurse (EN) working without a current practising certificate.</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.</p> <p>Nine staff files were reviewed (six caregivers, three RNs). Evidence of signed employment contracts, job descriptions, completed orientation that is specific to their job duties, and attendance at greater than eight hours of education and training annually were sighted. Annual performance appraisals for staff are conducted annually. Interviews with the care centre manager and caregivers confirmed that the orientation programme 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.</p> <p>There are implemented competencies for registered nurses including (but not limited to); medication, restraint, syringe driver and insulin administration.</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 service has a documented rationale for determining staffing levels and skill mixes for safe service delivery.</p> <p>At the time of the audit there were 36 residents (25 hospital level and 11 rest home level). The care centre manager is a registered nurse who is rostered Monday – Friday. She is supported by two RNs on the AM shift (one clinical nurse lead [CNL] and one RN, two RNs on the PM shift [or one RN and one enrolled nurse (EN)]) and one RN on the night shift. A staff RN is rostered on the days that the CNL is unavailable (Friday/Saturday). Extra RN staffing is also rostered in order to meet documentation requirements (eg, interRAI, care plans).</p> <p>Six caregivers are rostered on the AM shift (three long shifts and three short shifts). Six caregivers are also rostered on the PM shift (three long and three short shifts) and two caregivers are rostered on the night shift. With any increase in resident numbers and/or an increase in resident acuity, three caregivers would be rostered on the night shift.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded,</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. 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. Care plans and progress notes are documented electronically. Resident files demonstrate service integration.</p>

current, confidential, and accessible when required.		
<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>	FA	<p>There is an implemented Summerset admission policy and procedures to safely guide service provision and entry to the service. All residents have a needs assessment completed prior to entry that identifies the level of care required. The care centre manager and clinical nurse leader screen all potential enquiries to ensure the service can meet the required level of care and specific needs of the resident. The service has an information pack available for residents/families/whānau at entry. The admission information pack outlines access, assessment and the entry screening process. The service operates twenty-four hours a day, seven days a week. Comprehensive information about the service is made available to referrers, potential residents and their families. Resident agreements contain all detail required under the ARCC. The six admission agreements reviewed meet the requirements of the ARCC and were signed and dated. Exclusions from the service are included in the admission agreement.</p> <p>Family members and residents interviewed stated that they have received the information pack and have received sufficient information prior to and on entry to the service. Family members reported that the care centre manager or clinical nurse leader are available to answer any questions regarding the admission process.</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>	FA	<p>The service has a policy that describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident's electronic file. All relevant information is documented and communicated to the receiving health provider or service. Transfer notes and discharge information was available in resident records of those with previous hospital admissions. One file reviewed was of a resident who had been transferred to hospital acutely post fall. All appropriate documentation and communication were completed. Transfer to the hospital and back to the facility post-discharge was well documented in progress notes. Communication with family was made in a timely manner.</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 comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There was one resident self-administering on the day of audit. The resident had a current assessment, safe storage of their medication within their room and could describe the need and process for these when interviewed. All legal requirements had been met. There are no standing orders in use. There are no vaccines stored on site. All clinical staff (RNs, ENs) who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Registered nurses have completed syringe driver training. Staff were observed to be safely administering medications. Registered nurses and an enrolled nurse interviewed could describe their role regarding medication administration. The service currently uses robotics for regular medication and 'as required' medications. All medications are checked on delivery against the medication chart (medimap) and any</p>

		<p>discrepancies are fed back to the supplying pharmacy. Medications were appropriately stored in the facility medication room. The medication fridge and medication room temperatures are monitored daily, and the temperatures were within acceptable ranges. All medications including the bulk supply order are checked weekly. All eyedrops have been dated on opening.</p> <p>Staff sign for the administration of medications electronically. Twelve electronic medication charts were reviewed. The medication charts reviewed identified that the GP had reviewed all resident medication charts three monthly. Each drug chart has a photo identification and allergy status identified. 'As required' medications had indications for use charted.</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>The meals at Summerset on the Coast are all prepared and cooked on site. The kitchen was observed to be clean, well-organised and a current approved food control plan was in evidence. There is a twelve-weekly seasonal menu that is designed and reviewed by a registered dietitian at an organisational level. The chef receives resident dietary information from the RNs and is notified of any changes to dietary requirements (vegetarian, pureed foods) or of any residents with weight loss. The chef (interviewed) is aware of resident likes, dislikes and special dietary requirements. Alternative meals are offered for those residents with dislikes or religious preferences. Residents have access to nutritious snacks 24 hours a day. On the day of audit, meals were observed to be well presented.</p> <p>Kitchen fridge and freezer temperatures are monitored and recorded daily. Food temperatures are checked at all meals. These are all within safe limits. Staff were observed wearing correct personal protective clothing in the kitchen and in the serveries. Cleaning schedules are maintained. Staff were observed assisting residents with meals in the dining rooms and modified utensils are available for residents to maintain independence with meals. Food services staff have all completed food safety and hygiene courses. The food control plan expires 26 November 2021.</p> <p>The residents interviewed were very satisfied with recent changes in the food service and the variety and choice of meals provided. They can offer feedback on a one-to-one basis, at the resident meetings and through resident 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</p>	FA	<p>The service records the reason for declining service entry to potential residents should this occur and communicates this to the consumer and where appropriate their family/whānau member of choice. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.</p>

family/whānau is managed by the organisation, where appropriate.		
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. The initial support plan is developed by the registered nurses with information from the initial assessment and information provided from discharge summaries, allied health professionals and in consultation with the resident/relatives.</p> <p>The service uses VCare and interRAI assessments for all residents. These are completed on admission and reviewed six-monthly as part of the evaluation unless changes occur prior, in which case a review is carried out at that time. InterRAI assessments had been completed for all long-term residents' files reviewed. These were within timeframes and areas triggered were addressed in the care plans sampled.</p>
<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>Six resident files were reviewed across a range of conditions including (but not limited to) cognitive decline, diabetes, restraint, behaviour that challenges, falls, and weight loss. In all files reviewed the care plans were comprehensive, addressed the resident need and were integrated with other allied health services involved in resident care. Service integration was evidenced by documented input from a range of specialist care professionals, including the podiatrist, dietitian, rheumatology specialist and mental health care team for older people. Relatives and residents interviewed all stated they were involved in the planning of resident care. In all files reviewed there is evidence of resident and relative involvement in care planning. Activity assessments were completed by the activities staff within three weeks of admission. Care plans reviewed provided evidence of individualised support. Short-term care plans are in use for short-term needs and changes in health status. The care staff interviewed advised that the care plans were easy to follow. Integration of records and monitoring documents are well managed.</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>	FA	<p>The registered nurses complete care plans for residents. Progress notes in all files reviewed had details which reflected the interventions documented in the long-term care plans. When a resident's condition alters, the registered nurse initiates a review and if required, GP or specialist consultation. Short-term care plans are documented for changes in health status. Staff stated that they notify family members about any changes in their relative's health status. This was confirmed by family members interviewed, who stated they are notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. Evidence of relative contact for any changes to resident health status was viewed in the resident files sampled. Care plans reviewed documented sufficient detail to guide care staff in the provision of care. A physiotherapist is contracted to assess and assist residents' mobility and</p>

		<p>transfer needs as required.</p> <p>Wound assessment, appropriate wound management and ongoing evaluations are in place for all wounds. Wound monitoring occurred as planned and is documented on both a paper-based wound log and the VCare system. There were 10 ongoing wounds including; two abrasions, four skin tears, three minor lesion and one grade 1 pressure injury (facility acquired). There is a wound nurse specialist available for chronic wound 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 and this could be described by the RNs interviewed. Care staff stated there are adequate clinical supplies and equipment provided, including continence and wound care supplies, and these were sighted on day of audit.</p> <p>Monitoring charts sighted included (but are not limited to), vital signs, blood glucose, pain, food and fluid, turning charts, neurological observations, bowel monitoring and behaviour monitoring. All monitoring requirements including neurological observations had been documented as required.</p> <p>Care plans have been updated as residents' needs changed. The GP interviewed was complimentary of the service and care provided.</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>	<p>FA</p>	<p>The service employs two recreational therapists covering Monday to Sunday between them, who plan and lead the activities in the home. There are set Summerset activities including themes and events which the activities team add to in order to individualise activities to resident need and preferences. A weekly activities calendar is distributed to residents, posted on noticeboards and is available in large print. On the days of audit residents were observed participating in activities. The recreational therapist seeks verbal feedback on activities from residents and families to evaluate the effectiveness of the activity programme, enabling further adaptation if required. Residents interviewed were positive about the activity programme.</p> <p>Residents are able to participate in a range of activities that are appropriate to their cognitive and physical capabilities. There are two weekly outings to places chosen by the residents and there are regular entertainers visiting the facility. Special events like birthdays, Easter, Mothers' Day, Anzac Day and other cultural festive days are celebrated. There are visiting community groups such as local church groups, a village ladies craft group and men's shed group. The activity team provide a range of activities which include (but are not limited to) exercises, walks outside, crafts, games, quizzes, entertainers, baking and bingo.</p> <p>The activity team are involved in the admission process, completing the initial activities assessment, and have input into the cultural assessment. An activities plan is completed within timeframes, a monthly record of attendance is maintained, and evaluations are completed six-monthly.</p>

		Those residents who prefer to not to participate in communal activities receive one-on-one visits and individualised activities such as pampering sessions according to their preferences.
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	The six resident care plans reviewed had been evaluated by the registered nurses six-monthly or earlier if there was a change in health status. Activities plans are in place for each of the residents and these are also evaluated six-monthly. There are three-monthly reviews by the GP for all residents which family are able to attend if they wish to do so. Six monthly multi-disciplinary reviews and meeting minutes are completed by the registered nurse with input from caregivers, the GP, the recreational therapists, resident and family/whānau members and any other relevant person involved in the care of the resident. The contracted GP reviews the resident at least three-monthly. Short-term care plans are in use for acute and short-term issues. These are evaluated at regular intervals.
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>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>	FA	Summerset on the Coast facilitates access to other medical and non-medical services. Referral to other health and disability services is evident in the sample group of resident files. The RNs initiate referrals to nurse specialists, and allied health services. Other specialist referrals are made by the GP. Referrals and options for care were discussed with the family, as evidenced in medical notes. Referral documentation is maintained on resident files. The registered nurse interviewed gave examples of where a resident's condition had changed, and the resident care plan had been changed to reflect updated interventions accordingly. Discussion with the registered nurses identified that the service has access to a wide range of support either through the GP, specialists and allied health services as required.
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances,</p>	FA	There are policies and documented processes regarding chemical safety and waste disposal in place. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas. Safety datasheets and product sheets are available and readily accessible for staff. Sharp's containers are available and meet the hazardous substances regulations for containers. The hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff and were seen to be worn by staff when carrying out their duties on the day of audit. A spills kit is available.

generated during service delivery.		
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building holds a current building warrant of fitness, which expires on 9 February 2022. A request book for repairs is maintained and signed off as repairs are completed. There is a full-time maintenance officer who carries out the 52-week planned maintenance programme. The maintenance officer is also on call after hours for urgent matters. The checking and calibration of medical equipment including hoists, has been completed annually and is next due November 2021. All electrical equipment has been tested and tagged and is next due in November 2021. Hot water temperatures have been tested and recorded monthly with corrective actions for temperatures outside of the acceptable range. Preferred contractors are available 24/7.</p> <p>The corridors are wide and promote safe mobility with the use of mobility aids and transferring equipment. Residents were observed moving freely around the areas with mobility aids, where required. There is outdoor furniture and seating with shade in place, and there is safe access to all communal areas. The external areas are landscaped and are wheelchair accessible.</p> <p>The caregivers, RNs and EN interviewed stated that they have all the equipment required to 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 personal hygiene requirements.</p>	FA	<p>All bedrooms have hand basins. There are sufficient numbers of shower and toilet facilities in each of the three wings of resident rooms. Visual inspection evidence toilet and shower facilities are of an appropriate design to meet the needs of the residents and there is ample space in toilet and shower areas to accommodate shower chairs and a hoist if required. There are adequate numbers of communal toilets located near the communal areas. Communal toilets have a system that indicates if it is engaged or vacant.</p> <p>Fixtures, fittings, floorings and wall coverings are in good condition and are made from materials which allow for ease of cleaning.</p> <p>Residents interviewed reported their privacy is maintained at all times.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal</p>	FA	<p>All resident rooms are single and spacious enough to safely manoeuvre mobility aids and transferring equipment such as hoists in the resident bedrooms. The doors are wide enough for ambulance trolley access. Staff interviewed reported that they have more than adequate space to provide care to residents.</p> <p>Residents are encouraged to personalise their bedrooms with personal belongings as viewed on the day of</p>

space/bed areas appropriate to the consumer group and setting.		audit.
<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>There are large and small communal areas within the facility including a large main lounge that is partitioned from a smaller lounge with doors that open to the outdoors. There is a conservatory lounge at the end of each wing. The rest home wing of nine beds has its own dining room with kitchenette and tea making facilities.</p> <p>Activities occur in all lounges and dining areas which are large enough to cater for the activities on offer, are accessible and can accommodate the equipment required for the residents. There are sufficient lounges and private/quiet seating areas where residents who prefer quieter activities or visitors may sit. The lounge and dining areas are spacious, inviting and appropriate for the needs of the residents. Residents are able to move freely through and around these areas and furniture is placed to facilitate this. Residents were seen to be moving freely both with and without assistance during the audit.</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. There are designated cleaning/laundry staff on duty seven days a week. There is an entry and exit door with a defined clean/dirty area. The laundry is well equipped, and all machinery has been serviced regularly.</p> <p>There is a cleaning manual available. Cleaning and laundry services are monitored through the internal auditing system. Cleaning trolleys sighted were well equipped and are kept in designated locked areas when not in use. There are locked chemical boxes securely fixed to the cleaning trolley.</p> <p>Sluice rooms were kept locked when not in use. Residents and family interviewed reported satisfaction with the cleaning and laundry service.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>There is an emergency and civil defence plan to guide staff in managing emergencies and disasters. Emergencies and first aid are included in the mandatory in-service programme. There is a first aid trained staff member on every shift. Summerset on the Coast has an approved fire evacuation plan and fire drills occur six-monthly. Smoke alarms, sprinkler system and exit signs are in place. The service has alternative cooking facilities (barbeque) available in the event of a power failure. There is a 2000 litre tank, stored bottled water and lake water for use in an emergency. The service holds at least three days of food storage. Emergency power is used for lighting and call bells for up to two hours with torches readily available and solar lights that can be accessed from the garden areas. A generator is able to be accessed if necessary.</p>

		Call bells were evident in resident's rooms, lounge areas, and toilets/bathrooms. The facility is secured at night.
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	All bedrooms and communal areas are appropriately heated, have ample natural light and ventilation. The facility has under floor heating that is thermostatically controlled. Staff and residents interviewed stated that this is effective. All bedrooms and communal areas have at least one external window. There is a monitored outdoor area where residents may smoke. All other areas are smoke free.
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Staff are well-informed about infection control practises and reporting. The infection control officer (ICO) is an EN who is responsible for infection control across the facility as detailed in the ICO job description (signed copy sighted on day of audit). The ICO oversees infection control for the facility, reviews incidents on VCare and is responsible for the collation of monthly infection events and reports. The infection control committee and Somerset head office are responsible for the development and review of the infection control programme.</p> <p>Hand sanitisers are appropriately placed throughout the facility. Visitors are asked not to visit if they are unwell. Residents are offered the influenza vaccine. There was one outbreak in 2020 and one in 2021 which were appropriately managed.</p> <p>Covid-19 education has been provided for all staff, including hand hygiene and use of PPE.</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</p>	FA	There are adequate resources to implement the infection control programme at Somerset on the Coast. The ICO liaises with the infection control committee who meet two monthly and as required (monthly during Covid lockdown). Information is shared as part of staff meetings and also as part of the registered nurse meetings. The ICO has completed annual training in infection control. External resources and support are available through the Somerset regional quality manager, external specialists, microbiologist, GP, wound nurse and DHB when required. The GP monitors the use of antibiotics. Overall effectiveness of the programme is monitored by Somerset head office.

meet the needs of the 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>The infection control policies include a comprehensive range of standards and guidelines including defined roles and responsibilities for the prevention of infection, the infection control team, and training and education of staff. Infection control procedures developed in respect of care, the kitchen, laundry and housekeeping incorporate the principles of infection control. Policies are updated regularly and directed from Somerset head office.</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 ICO is responsible for coordinating/providing education and training to staff. The orientation package includes specific training around hand hygiene and standard precautions. Annual infection control training is included in the mandatory in-services that are held for all staff, and staff have completed infection control education in the last 12 months. The infection control officer has access to the Somerset ILearn intranet with resources, guidelines best practice, education packages and group benchmarking. The ICO has also completed infection control audits.</p> <p>Resident education occurs as part of providing daily cares and as applicable at resident meetings.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been</p>	FA	<p>Surveillance is an integral part of the infection control programme and the purpose and methodology are described in the Somerset surveillance policy. The infection control officer uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility.</p> <p>Monthly infection data is collected for all infections based on standard definitions as described in the surveillance policy. Infection control data is monitored and evaluated monthly and annually. Trends are identified, and analysed, and preventative measures put in place. These, along with outcomes and actions are</p>

<p>specified in the infection control programme.</p>		<p>discussed at the infection control meetings. Meeting minutes are available to staff.</p> <p>Infections are entered into the electronic database (VCare) for benchmarking. Corrective actions are established where trends are identified.</p> <p>Systems in place are appropriate to the size and complexity of the facility.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>There are policies around restraints and enablers. The service had two (hospital) residents assessed as requiring the use of restraint (two bedrails and one lap belt) and one resident (hospital) requiring an enabler (bedrails). The care plans provide the basis of factual information in assessing the risks of safety and the need for restraint. Ongoing consultation with the resident and family/whānau are identified. Staff receive training around restraint minimisation that includes annual competency assessments.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>A restraint approval process and a job description for the restraint coordinator are in place. The restraint coordinator role is delegated to a registered nurse. They have been in this role for seven years. All staff are required to attend restraint minimisation training annually.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>Only registered nursing staff can assess the need for restraint. Restraint assessments are based on information in the resident's care plan, discussions with the resident and family and observations by staff. The restraint assessment tool meets the requirements of the standard. Two hospital level residents' files where restraint was being used were selected for review. Each file included a restraint assessment and consent form that was signed by the resident's family. Restraint use is linked to the resident's care plan and is regularly reviewed.</p>

<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>A restraint register is in place. This register identifies the residents that are using a restraint, and the type(s) of restraint used. The restraint assessment identified that restraint is being used only as a last resort. The restraint assessment and ongoing evaluation of restraint use includes reviewing the frequency of monitoring residents while on restraint. Monitoring forms are completed when the restraint is put on and when it is taken off and indicate monitoring at the frequency described in each resident's care plan.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>Restraint use is reviewed monthly during restraint meetings and three-monthly by the restraint coordinator. The review process includes discussing whether continued use of restraint is indicated.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The restraint programme, including reviewing policies and procedures and staff education, is evaluated annually by the Somerset head office.</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.

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, 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 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>The service continues to enhance service delivery for residents' end stage of life.</p>	<p>The service is active in identifying ways to care for residents during their last days of life. With the support of the Mary Potter Hospice Aged Residential Care (ARC) Specialist Palliative Care Advisor, they continue to strengthen their focus on palliative care through a wide variety of measures including (but not limited to) staff education, advance care planning, building strong networks, family and resident involvement, the implementation of palliative care assessment tools, and spiritual support. Education sessions cover the fundamentals of palliative care, pain management, assessment, and early recognition of deteriorating health for those residents with life-limiting conditions.</p> <p>Three RNs including the clinical nurse leader (CNL) have attended the palliative care link nurse programme which involved 16 hours of theoretical learning and 24 hours of clinical work within Mary Potter Hospice. This included completing a project to bring 'a piece of learning' back to the facility to share with colleagues. Residents and family are encouraged to be involved in advance care planning and decision-making about their care to ensure their end-of-life wishes are known and acted upon. The CNL meets with families and the RNs to encourage discussion and advance care planning. Te Ara Whakapiri</p>

			<p>principles and guidance for the last days of life have been implemented over the past year. There is multidisciplinary input into the plan, which is supported by the GP. An interview with the GP confirmed that Summerset on the Coast is a centre of excellence in their approach to palliative care. Written compliments from bereaved families have been received, some which include “treated with utmost respect, dignity and love”, “astonished at the level of care and compassion shown”, “expert and personal care”, “fantastic support”.</p>
<p>Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	CI	<p>Falls have reduced over the past 2020 calendar year and are below the threshold for Summerset care centres.</p>	<p>Data collected and collated are used to identify areas that require improvement. Clinical indicator data has individual reference ranges for acceptable limits. Residents falls are monitored monthly with strategies implemented to reduce the number of falls including: highlighting residents at risk; providing falls prevention training for staff; ensuring adequate supervision of residents; and encouraging resident participation in the activities programme; physiotherapy assessments for residents at risk; routine checks of all residents specific to each resident’s needs (intentional rounding); the use of sensor mats; and increased staff awareness of residents who are at risk of falling.</p> <p>Caregivers and RNs interviewed were knowledgeable in regard to preventing falls and those residents who were at risk. The falls prevention programme has been reviewed monthly and is regularly discussed at relevant meetings. The facility’s rolling six-month trend for falls is approximately 40% lower than all of Summerset care centres. Over the last 12 months (January – December 2020) the six-month rolling trend for the fall’s indicator has trended downwards and then stabilised, having fallen from a high of 6.2 incidents/1,000 bed nights in February 2020 to 5.1 incidents/1,000 bed nights in June 2020, and then falling further and stabilising at approximately 4.5 incidents/1,000 bed nights in December 2020.</p>
<p>Criterion 1.3.13.1 Food, fluid, and nutritional needs of consumers are provided in line with recognised</p>	CI	<p>Summerset on the Coast has introduced a number of initiatives to ensure residents nutritional needs are met and the dining experience improved. The main project was commenced following the resident satisfaction survey in 2018 and</p>	<p>Catering has been moved from being outsourced to in-house caterers. The four-week rotating seasonal menu has been increased to a 12-week rotation and offers a variety of choices including gluten free and vegetarian options. The service has liaised with food suppliers to improve quality of suppliers including access to specialised pure foods for pre-moulded pureed options. Other initiatives include an easy-to-read larger menu board with white chalk paint. Kitchen equipment and tableware have been reviewed, and new purchases</p>

<p>nutritional guidelines appropriate to the consumer group.</p>		<p>results have been evaluated in the 2020 resident satisfaction survey.</p>	<p>made to ensure timely delivery of meals at the desired temperature.</p> <p>Staff have received training in dining room etiquette and food presentation. Dining room settings have been reviewed to maximise socialisation among residents and linen tablecloths, flowers and linen napkins have been introduced to enhance the resident dining experience. The lighting and shades in the dining rooms (viewed) have been set up to reflect an ambience of relaxed dining as observed during mealtimes.</p> <p>Evaluation of the project and dining experience has been measured by; 1) feedback from residents and families at the regular friends and family advocacy meetings. There have been very positive comments recorded in the minutes sighted since the introduction of the project, 2) ongoing education for staff around food services, dining room etiquette, nutrition and hydration, 3) Resident surveys sighted evidenced residents and relatives are very satisfied with the meals and choices provided (89% from 65% satisfaction) and 4) interviews with residents and families on the day of audit all confirmed that the meals (choice, quality and presentation) were very good to excellent. The service has been successful in providing excellence in food services.</p>
<p>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</p>	<p>CI</p>	<p>Infection events are collated monthly and areas for improvement are identified and corrective actions developed and followed up. The facility is benchmarked against other Summerset facilities of similar size and benchmarking results are fed back to the infection control officer and used to identify areas for improvement. Surveillance results are used to identify infection control activities and education needs within the facility. The service has successfully reduced incidences of all infections with a particular focus upon urinary tract infections (UTIs).</p>	<p>The service identified that over the last 12 months overall infection rates have trended downwards, falling from 4.0 incidents/1000 bed nights to 2.0 incidents/1000 bed nights. This is less than half the average of that experienced by other Summerset facilities. UTIs have fallen from 0.9 incidents/1000 bed nights to 0.4 incidents/1000 bed nights and are a third of the average UTI infection rate of other Summerset facilities.</p> <p>Since experiencing a spike in UTIs the service has implemented and maintained a focus of staff training in this area, particularly relating to perineal hygiene. The GP works in with the service and requires a positive test result prior to any treatment commencing. The service has successfully reduced and maintained the incidence of UTIs in rest home and hospital residents below the organisational KPI (1.5 per 1000 bed days) for UTIs.</p>

management in a timely manner.			
--------------------------------	--	--	--

End of the report.