Summerset Care Limited - Summerset at Aotea

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 at Aotea
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 18 June 2018 End date: 19 June 2018

Proposed changes to current services (if any):

Total beds occupied across all premises included in the audit on the first day of the audit: 18

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 at Aotea provides rest home level care for up to 46 residents living in apartments within a village complex. On the day of the audit, there were 17 rest home residents. The village manager is non-clinical with two and a half years' experience in the health sector. The village manager is supported by a clinical manager/registered nurse that has been in the position since September 2017, and a regional operations manager. The residents and relatives interviewed spoke positively about the care and supports provided at the service.

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

This audit has identified improvements required around complaint management, staff education/appraisals and implementation of care.

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

Summerset at Aotea has a culture of open disclosure that is implemented. Complaints and concerns information is made available to residents and their families.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.

Summerset at Aotea has a documented quality and risk management system. Key components of the quality management system link to facility. Annual surveys and monthly resident meetings provide residents and families with an opportunity for feedback about the service. Quality performance is reported to staff at meetings and includes discussion about incidents, infections and internal audit results. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care. Staffing levels and skills mix policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.

The clinical nurse leader and registered nurse complete assessments, interRAI assessments, care plans and evaluations within the required timeframes. Risk assessment tools and monitoring forms are available.

A diversional therapist for the rest home residents and a recreational therapist for the village coordinate and implement an integrated activity programme. The activities meet the individual recreational needs and preferences of the consumer groups. There are outings into the community and visiting entertainers.

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

The food service is contracted to an external company. Resident's individual dietary needs were identified and accommodated. Staff have attended food safety and hygiene training. Residents commented positively on the meals provided.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.

The building has a current warrant of fitness.

Restraint minimisation and safe practice

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

A restraint policy includes comprehensive restraint procedures. A documented definition of restraint and enablers aligns with the definition in the standards. There were no residents with enablers or on restraint at the time of the audit. Staff are trained in restraint minimisation and managing behaviours that challenge.

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 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.

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	13	0	3	0	0	0
Criteria	0	38	0	3	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
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	PA Low	The organisational complaints policy states that the village manager has overall responsibility for ensuring all complaints (verbal or written), are fully documented and investigated. The electronic complaints register did not always include relevant information regarding the complaint. There have been four complaints in 2017 and 2018 to date. One of these complaints was through the Health and Disability Commission in April 2018. The complaint has been investigated and closed with no further action required by the service. Discussion around complaints is a standing agenda item for the various facility meetings. A complaints procedure is provided to residents within the information pack at entry. Feedback forms are available for residents/relatives in the facility. Residents and relatives interviewed were aware of the complaints process and said they would feel comfortable to make a complaint if required.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective	FA	Five residents and three family members interviewed stated they were welcomed on entry and given time and explanation about services and procedures. Family members interviewed also stated they are informed of changes in the resident's health status and of incidents/accidents. Resident/relative meetings are held every three months with an advocate from Age Concern present. The village manager and the clinical nurse leader have an open-door policy. The service produces a newsletter for residents and relatives. Twelve incident forms sampled all demonstrated that next of kin were notified of the incident. The service has policies and procedures available for access to interpreter services for residents (and their family/whānau). If residents or family/whānau

communication.		have difficulty with written or spoken English, the interpreter services are made available.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Summerset at Aotea provides care for up to 46 residents at rest home level care in a serviced apartment complex. On the day of audit there were 17 residents receiving rest home level care (including four residents on respite). All permanent residents were under the ARC contract. Summerset Group Limited Board of Directors have overall financial and governance responsibility and there is a company strategic business plan in place. Summerset at Aotea has a site-specific business plan and goals that has been developed in consultation with the village manager, clinical nurse leader and regional operations manager. The Summerset at Aotea quality plan is reviewed regularly throughout the year. A full evaluation has been conducted for 2017. A non-clinical village manager who has been in the position for 18 months, manages the service. The clinical nurse leader (CNL), who is a registered nurse, was absent for the first day of the audit. The CNL has been in the position since September 2017 and supports the village manager. A registered nurse with 14 years aged care experience, (four as a registered nurse), was filling the clinical nurse leaders position for the first day of the audit. A regional operations manager and a clinical education manager based at the head office also provide support. Village managers and clinical nurse leaders attend annual organisational forums and regional forums over two days each year for training and support.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	Summerset at Aotea is implementing the organisation's quality and risk management system. There were gaps in implementation of internal audits between June and December 2017 between clinical managers. The quality and risk management systems including internal audits have been fully completed and kept up-to-date since January 2018, and therefore no partial attainment has been raised for this. There are policies and procedures being implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed on a regular basis. The content of policy and procedures are detailed to allow effective implementation by staff. The Summerset group has a 'clinical audit, training and compliance' calendar. The calendar schedules the training and audit requirements for each month and the clinical nurse leader completes a 'best practice' sheet confirming completion of requirements. The best practice sheet reports (but not limited to) meetings held, induction/orientation, audits, competencies and projects. This is forwarded to head office as part of the ongoing monitoring programme. There is a meeting schedule including monthly quality improvement (full facility) meetings that includes discussion about clinical indicators (eg, incident trends, infection rates). Health and safety, infection control and

		restraint meetings occur three monthly. There are other facility meetings held, such as kitchen and activities. The documented internal audit programme includes aspects of clinical care. Issues arising from internal audits are developed into corrective action plans. Monthly and annual analysis of results is completed and provided across the organisation. An annual residents/relatives survey completed (2017) reports overall 100% feedback of experience being good or very good. There are monthly accident/incident benchmarking reports completed by the clinical nurse leader that break down the data collected across the rest home and staff incidents/accidents. Infection control is also included as part of benchmarking across the organisation. Health and safety internal audits are completed, and corrective actions are required based on benchmarking outcomes. All incidents and infections are entered into the integrated VCare electronic system. There is a health and safety, and risk management programme in place including policies to guide practice. The two health and safety representatives interviewed have both been externally trained and were familiar with the goals in the current health and safety plan. They are responsible for providing health and safety inductions to new staff. Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. Summerset at Aotea also provides new residents with two pairs of non-slip socks in the resident's welcome pack.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	Incident and accident data has been collected and analysed. Discussions with the service confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Twelve resident related incident reports were reviewed. All reports and corresponding resident files reviewed evidence that appropriate assessment and clinical care (except neurological observations – link 1.3.6.1) has been provided following an incident. The incident reporting policy includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Data is linked to the organisation's benchmarking programme and is used for comparative purposes. The village manager described appropriate occasions requiring essential notifications. None have been required since the previous audit.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good	PA Low	There are human resources policies to support recruitment practices. A list of practising certificates is maintained. Five staff files (one clinical nurse leader, one RN, one recreational therapist, and two caregivers) were reviewed, and all had relevant documentation relating to employment. Performance appraisals had not always been completed annually. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme includes documented competencies and induction checklists (sighted in files of newly appointed staff). Staff interviewed were able to describe the

employment practice and meet the requirements of legislation.		orientation process and believed new staff were adequately orientated to the service. There is an annual education plan that is outlined on the 'clinical audit, training and compliance calendar'. The plan has not been fully implemented, however, a corrective action is in progress to correct this. A competency programme is in place with different requirements according to work type (eg, caregivers, registered nurse and kitchen). Core competencies are completed, and a record of completion is maintained on staff files. Staff interviewed were aware of the requirement to complete competency training. Caregivers complete an aged care programme.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	The village manager and clinical nurse leader (CNL) each work 40 hours per week (Monday to Friday) and are available on call for any emergency issues or clinical support. There is one registered nurse (either the clinical nurse leader (CNL) or the registered nurse) on day shift seven days per week. On morning shift one caregiver works from 6.45 am to 3.15 pm and another from 7.00 am to 12.30 pm. On afternoon shift one caregiver works from 3.00 pm to 11.15 pm and another from 5.00 pm to 11.00 pm. Overnight there are two caregivers, which is appropriate given the layout of the complex. The caregivers are also responsible for nine village residents on care support packages. Seven are on basic packages and two are on supported living plus which includes assisted showers In addition, there is a DT from 9.00 am to 5.00 pm, Monday to Friday. A staff availability list ensures that staff sickness and vacant shifts are covered. Three caregivers and one registered nurse interviewed confirmed that staff are replaced. Staffing levels and skills mix policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery. Residents and family interviewed also advised that there were sufficient staff rostered on.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	There are medicine management policies and procedures that align with recognised standards and guidelines for safe medicine management practice in accordance with the Medicines Care Guide for Residential Aged Care 2011. The CNL, RN and senior caregivers are responsible for the administration of medications for rest home residents. Care staff complete competencies for the checking and witnessing of medications as required. Medication competencies and education have been completed annually. All medications were checked on delivery with any discrepancies fed back to the supplying pharmacy. There were no self-medicating rest home residents at the time of the audit. All medications were stored correctly. Ten electronic resident medication charts and corresponding medication administration records were reviewed. The medication charts had photograph identification and allergy status recorded. Staff recorded the time and date of 'as required' medications. All 'as required' medications had an indication for use. All medication charts reviewed identified that the GP had reviewed the medication chart three monthly.

Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	An external food service company is contracted for the provision of meals on-site, and to the village café. The kitchen and main dining area is located on the second level. There is a six-week rotating menu, which has been approved by the organisational dietitian. Resident likes/dislikes and preferences are known and accommodated with alternative meal options. The chef manager provides 'fine dining' and a chef's choice based on suggestions from residents. Special texture-modified meals, fortified foods, protein drinks and diabetic desserts are provided. Kitchen staff receive a dietary profile for each resident. The qualified chef manager (interviewed) is notified of any changes to resident's dietary requirements/preferences. The fridge, freezer and end-cooked food temperatures are recorded twice daily. All foods are stored correctly, and date labelled. Cleaning schedules are maintained. Chemicals are stored safely within the kitchen. Staff were observed wearing correct personal protective clothing. The chemical provider completes a monthly functional test on the dishwasher. The service has continued to implement improvements to the food service and respond to resident feedback promptly. As a result of this, satisfaction with the meal service has continued to improve each year as documented in the resident survey. The 2016 survey documented that 50% of residents were very satisfied with the meal service and the 2017 survey saw this increase to 67%
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Low	The RN initiates a review and if required, a GP or nurse specialist consultation when a resident's condition changes. Care plans sampled addressed all residents' needs and goals and caregivers reported they are easy to follow. There is close registered nurse oversight with a registered nurse being on duty and undertaking clinical reviews seven days per week. However, neurological observations are not always completed when required. Relatives interviewed stated their relative's needs are met and they are kept informed of any health changes. There was documented evidence in the resident files of family notification of any changes to health, including infections, accidents/incidents, and medication changes. Residents interviewed stated their needs are being met. Adequate dressing supplies were sighted. Initial wound assessments with ongoing wound evaluations and treatment plans were in place for five minor wounds. Photographs are used as part of the wound assessment and evaluation process. The registered nurse reported that the wound nurse specialist is available if required. 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. There are a number of monitoring forms and charts available for use including (but not limited to) pain monitoring (although inadequate), blood sugar levels, weight, wound evaluations, food and fluid intake.

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 for the rest home and apartment residents and a recreational therapist for the village. The activity team attends Summerset training sessions and the regional DT group. Both activity persons have current first aid certificates. The rest home residents' programme is planned a month in advance and includes set activities, with the flexibility to add other activities of interest or suggestions made by residents. Activities meet the recreational needs of the residents, ensuring all residents have the opportunity for outings, shopping, and attending community groups/events including concerts, functions and lunches. Community visitors include monthly entertainers. There are meaningful activities that are integrated with rest home and village residents. There are four volunteers that assist with activities. Residents are encouraged to maintain their former community links. Church services are held. The service has a van for the outings. Resident meetings provide an opportunity for residents to feedback on the programme. The diversional therapist completes activity assessments and plans and is involved in the multidisciplinary review, which includes the review of the activity plan.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	There is evidence of resident and family involvement in the review of resident centred care plans. The registered nurses had evaluated all initial care plans of the permanent residents within three weeks of admission. Written evaluations had been completed 6 monthly. InterRAI reviews are completed at the same time as care plan evaluations. There is evidence of multidisciplinary (MDT) team involvement in the reviews, including input from the GP and any allied health professionals involved in the resident's care. Families are invited to attend the MDT review and they are asked for input if they are unable to attend. An RN has evaluated short-term care plans (sighted). The GP completes three monthly reviews.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	There are established systems in place to ensure the physical environment and facilities are safe and fit for their purpose. The building has a current building warrant of fitness that expires on 13 October 2018. Maintenance is undertaken by both internal staff and external contractors and the facility is maintained in good repair.

Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The infection control policy includes surveillance procedures. Infection events are collected monthly and entered onto the SWAY electronic system. The infection control officer provides infection control data, trends and relevant information to the infection control committee and clinical/quality meetings. Areas for improvement are identified, 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. Infection control audits are completed (link 1.2.3.6) and corrective actions signed off (sighted). Surveillance results are used to identify infection control activities and education needs within the facility. There have been no outbreaks since the previous audit.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	A restraint policy includes comprehensive restraint procedures. A documented definition of restraint and enablers aligns with the definition in the standards. There are currently no residents with enablers or restraint. Staff are trained in restraint minimisation and managing behaviours that challenge. The service is committed to restraint minimisation and safe practice as evidenced in the restraint policy and interviews with the caregivers.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.1.13.1 The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.	PA Low	The service has an electronic complaint register and evidence available demonstrated that two of the four complaints reviewed had been managed and documented in keeping with the requirements of Code 10 of the Code.	Two of the four complaints reviewed did not evidence that responses were made in line with Code 10 of the Health and Disability Commissioners Code of Consumer Rights (the Code).	Ensure all complaints are acknowledged within five days and that the outcome of the investigation is provided to the complainant for all complaints. 90 days
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	Summerset provides all sites with an education calendar which, when adhered to ensures staff receive all required training. The schedule has not been fully implemented. Policy dictates that all staff have an annual performance appraisal, and this had occurred in three of five staff files sampled.	(i) Not all required staff training has been provided as scheduled. Missed trainings included chemical safety, continence and abuse and neglect. (ii) Two of five staff files sampled had not had an annual performance appraisal completed.	(i) Ensure staff receive all required training. (ii) Ensure all staff have an annual performance appraisal. 90 days

Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Low	Summerset policy and procedures dictate that neurological observations should be completed for all unwitnessed falls. This is not occurring. Pain monitoring forms are used but do not include all required information.	(i) Neurological observations were not completed for eight of eight incident forms reviewed where the resident had unwitnessed falls and potentially hit their head. (ii) The pain monitoring chart described the pain but not the cause, intervention or effectiveness.	(i) Ensure neurological observations are completed for all unwitnessed falls where the resident may have potentially hit their head. (ii) Ensure full pain monitoring occurs for residents that experience pain. 60 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.