Summerset Care Limited - Summerset Down The Lane

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 down the Lane
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 15 February 2019 End date: 15 February 2019

Proposed changes to current services (if any): The service has increased bed numbers from 49 – 51 beds in the care centre by reconfiguring two single rooms to double rooms for couples.

The service has increased rest home level residents in certified serviced apartments from 10 residents up to 15 residents.

Total beds occupied across all premises included in the audit on the first day of the audit: 59

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 Down the Lane currently provides rest home and hospital levels of care for up to 51 residents in the care centre and up to 15 residents in serviced apartments. During the audit, there were 48 residents in the care centre and 11 rest home level of care residents in serviced apartments.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management and staff. This audit also included verifying the suitability of two rooms in the care centre as suitable as a double room for couples. This increases bed numbers in the care centre from 49 to 51 beds. The audit also included verifying the suitability of increasing rest home level residents in certified serviced apartments from 10 residents up to 15 residents.

The village manager is appropriately qualified and has been in the role six months. She is supported by a regional manager, non-clinical care centre manager and a clinical nurse manager. There are quality systems and processes established. Feedback from the residents and families was very positive about the care and services provided.

The previous finding in relation to the corridor link and overbridge to the serviced apartments has been addressed.

There were no shortfalls identified at this surveillance audit.

Consumer rights

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

The service promotes open disclosure and have an open-door policy. A complaints process is implemented, and complaints and concerns are managed appropriately. Resident meetings and advocate meetings are held regularly. Family confirmed they are kept informed on their relative's health status.

Organisational management

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

Services are planned, coordinated, and are appropriate to the needs of the residents. A care centre manager and a clinical nurse manager/registered nurse are responsible for the day-to-day operations of the care facility and serviced apartments. Quality and risk management processes are established. Strategic plans and quality goals are documented for the service. A risk management programme is in place, which includes a risk management plan, incident and accident reporting, and health and safety processes. Adverse, unplanned and untoward events are documented by staff. The health and safety programme meets current legislative requirements.

Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. A staff education and training programme is embedded into practice.

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

Continuum of service delivery

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

Registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family input. Care plans viewed demonstrated service integration and are reviewed at least six monthly. Resident files include medical notes by the contracted general practitioner/nurse practitioner and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and senior caregivers are responsible for the administration of medicines. Medication charts are reviewed three monthly by the general practitioner/nurse practitioner.

The diversional therapist implements 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 celebrations.

All meals are cooked on site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated.

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 warrant of fitness.

Restraint minimisation and safe practice

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

Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort. There were five residents using restraint and three residents were using enablers. Staff receive regular education and training on restraint minimisation.

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 coordinator 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 no outbreaks.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	17	0	0	0	0	0
Criteria	0	43	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The service has a complaints policy that describes the management of the complaints process. Information about the complaints process is provided on admission. Complaints forms are readily available. Interviews with residents (one hospital and three rest home) and family members, confirmed their understanding of the complaints process. Care staff interviewed were also able to describe the process around reporting complaints. An electronic complaints register is maintained. Seven complaints have been lodged in the complaints register for 2018. Evidence was sighted to confirm that each complaint had been managed in a timely manner including acknowledgement, investigation, feedback to the complainant and resolution. Corrective actions from previous complaints have been implemented and maintained. There has been one complaint received by the DHB January 2019 and the service is in the process of investigating and responding to the DHB. Complaints received are communicated to staff as evidenced in the staff meeting minutes.
Standard 1.1.9: Communication Service providers communicate effectively with	FA	An open disclosure policy describes ways that information is provided to residents and families. The admission pack includes information regarding the scope of services provided to the resident on entry to the service, and any items they have to pay for that is not covered by the agreement. Regular contact is maintained with families including when an incident or care/health issues arise, evidenced in 15 accident/incident forms that were randomly selected for review. Interviews with families (three rest home and one hospital) confirmed that they are kept

consumers and provide an environment conducive to effective communication.		informed. There is a resident meeting monthly, and a three-monthly meeting with an advocate providing residents with an opportunity to discuss all areas of service. Residents and relatives receive three monthly newsletters. A formal agreement is in place with an external provider for interpreter and translation services.
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 Down the Lane is certified to provide rest home and hospital levels of care in their care facility for up to 51 residents (includes two double rooms that were verified as suitable for couples at this audit). On the day of the audit there were 48 residents in the care facility (16 at rest home level and 32 at hospital level). All residents' rooms in the care facility are certified for dual-purpose. There are 50 serviced apartments certified for rest home level (with a maximum of up to 10 residents at rest home level at one time as per HealthCERT letter dated 6 October 2017). Following a request for a further five rest home residents in serviced apartments (HealthCERT letter 3 Sept 2018), this audit also included verifying the suitability of the building, staffing, location, as suitable to provide rest home level care from 10 up to 15 residents. Currently there are 11 residents as rest home level of care in the serviced apartments. A village manager is responsible for the retirement village. She was appointed in August 2018 and has 16 years of non-clinical experience within the aged care industry. She is supported by a non-clinical care centre manager who has been in the role since May 2017 and has previous experience as an operations manager with an aged care company. The clinical nurse manager/registered nurse (previously the clinical nurse leader) was appointed to the role in July 2017 with the change in management structure with both managers being non-clinical. The organisation has an overarching business plan based on the organisation's philosophy, vision and values. A site-specific business plan for 2018 has been reviewed and new goals set for 2019 including (but not limited to: falls reduction, incorporating small group activities for residents with dementia and mentoring level 4 caregivers into roles as caregiver "coaches". The service is involved in a pilot project for dementia friendly facilities. In 2018 Summerset Down the Lane was awarded the Summerset care centre of the year. The village manager and care centre manager have attended at least eight hours of professional development related to their roles including attending ARCC forums, Summerset regional meetings and Summerset annual conference.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established,	FA	The quality and risk management programme are established through the Summerset head office. 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. The managers are held accountable for their implementation. Interviews with the staff (two caregivers, one RN and one enrolled nurse, one recreational officer and one health and safety representative) confirmed their understanding of the quality and risk management systems that are being implemented.

documented, and maintained quality and risk management system that reflects continuous quality improvement principles.		The monthly collating of quality and risk data includes (but is not limited to) residents' falls, infection rates, skin tears, pressure areas, restraint, complaints and survey outcomes. Data is collated and analysed to identify trends. An annual internal audit schedule is being implemented with audits completed as per the schedule. Evidence was sighted across a variety of applicable meeting minutes (management, Quality, RN, staff, health and safety and infection control meetings) and confirmed that quality data and results were being communicated to staff. All meeting minutes and data is available in a staff reading folder in the staff room. Corrective actions are developed where opportunities for improvements are identified. Sighted was evidence of the implementation and evaluation of corrective action plans that had been established, and evidence that corrective actions are discussed with staff. The annual resident/relative survey was completed September 2018. Areas identified for improvement were around meals and activities. Action plans were developed, implemented and monitored through regular audits and resident meetings. New roles (October 2018) within the head office include a DT to support all care centres and a food services manager to oversee the food services across all sites. The health and safety programme meets current legislative requirements. It is overseen by a health and safety officer (property manager), and is supported by a health and safety team. Monthly health and safety committee meetings are held when all accident/incident data and hazards are reviewed. A health and safety representative (interviewed) has been in the role six months and completed stage one of health and safety course. A contractor induction programme is in place. There is a current hazard register. Staff have completed health and safety training including safe manual handling, emergency evacuation (including the use of the evacuation chair and location of transfer board). All staff interviewed confirmed their awareness of training and location of equipment in the event of an emergency. Falls prevention strategies are being implemented. This includes the implementation of interventions on a case-by-case basis to minimise future falls and ensuring all residents requiring sensor mats have these in place. Physiotherapy services are utilised
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported	FA	The service collects a comprehensive set of data relating to adverse, unplanned and untoward events, which is linked to the quality and risk management system. Fifteen accident/incident forms were reviewed. Data is collected and stored in an electronic format. Immediate actions taken are documented. The forms are reviewed and investigated by the clinical nurse manager and are then signed off by the care centre manager. If risks are identified, these are processed as hazards and are reported to the health and safety team. Discussion with the village manager confirmed her awareness of statutory requirements in relation to essential notification with appropriate action taken where required. There has been no resident related essential notifications to report. HealthCERT was notified by section 31 when the new village manager was appointed August 2018.

to affected consumers and where appropriate their family/whānau of choice in an open manner.		
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	Job descriptions are in place for all relevant positions that describe staff roles, responsibilities and accountabilities. The practising certificates of registered and enrolled nurses, and allied health practitioners were current. Six staff files were reviewed (clinical nurse manager, two RNs, two caregivers and one diversional therapist). Evidence of signed employment contracts, job descriptions, orientation, and staff training were sighted. Newly appointed staff complete an orientation that is specific to their job duties. Interview with caregivers confirmed that the orientation programme included a period of supervision until competency was achieved. Annual performance appraisals for staff are regularly conducted. Four of seven RNs are interRAI trained. The service has a training policy and schedule for in-service education. The in-service schedule is implemented, and attendance is recorded. Staff who do not attend are required to read the education content and sign to declare they have understood the content. Repeat education sessions are offered and there are tool box talks at handovers. Four caregiver coaches who are currently being mentored will orientate new staff as part of their role. There is a system for determining staff competency as related to their roles including medication, syringe driver, oxygen and insulin administration, safe manual handling, restraint competency, hand hygiene and first aid. The 2019 goal around staff education is to implement two staff training days a year with the first scheduled to occur in March 2019. The training day will include compulsory education in the morning and clinical education in the afternoons. The care centre manager is a Careerforce assessor up to level two. The clinical nurse manager is an assessor up to level two.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced	FA	The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. The village manager and care centre manager are non-clinical and work full-time and on-call for non-clinical matters. The clinical nurse manager/registered works full-time Monday to Friday. The registered nursing team has been stable. Care Centre: The beds are all dual-purpose. Residents requiring closer supervision and of higher acuity are positioned in the wing closest to the nursing station. There are two RNs or one RN and one enrolled nurse (EN) on duty for the morning shifts. There are three caregivers on the full shift and four caregivers on the short shift with three finishing at 1.30 pm and one at midday.

service providers.		On the afternoons there are either two RNs or one RN and one EN. There are three caregivers on full afternoon shifts and three on the short shift finishing at 9.00 pm. On night shift there is two RNs or one RN and one EN plus two senior caregivers. The roster can be changed in response to resident acuity. Serviced apartments: The service appointed a part-time (three days a week) service coordinator (non-clinical) in January 2019 to oversee and support the serviced apartment staff. There are two caregivers on morning duty (one each floor) and two on the afternoon shift between the floors and one on night shift. There is a nurse's station in the serviced apartment area. Registered nursing support is provided by the care centre RNs. There are separate laundry and cleaning staff, seven days a week. Activities staff are scheduled from Monday to Sunday. Interviews with residents and families confirmed that they felt there was sufficient staffing.
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 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. All documentation requirements had been met. There are no standing orders in use. There are no vaccines stored on site. Serviced apartment medications are kept on a trolley in a locked cupboard. The facility uses an electronic and robotic pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. RNs and senior medication competent caregivers administer medications. Staff have up to date medication competencies and there has been medication education in the last year. Four RNs have syringe driver training completed by the hospice. The medication fridge temperature is checked daily. Eye drops are dated once opened. Staff sign for the administration of medications electronically. Ten medication charts were reviewed. Medications are reviewed at least three monthly by the GP/NP. There was photo identification and allergy status recorded. 'As required' medications had indications for use charted.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids	FA	All food is cooked on-site by a contracted company. The service has a kitchen manager who works Tuesday to Saturday and a cook who works Sunday to Monday. There are six kitchenhands and there are two on each day. All have current food safety certificates. The kitchen manager oversees the procurement of the food and management of the kitchen. There is a well-equipped kitchen. Meals are taken to the dining rooms in hot boxes, transferred to a bain marie and served directly from these. Meals going to rooms on trays have covers to keep the food warm. Special equipment such as lipped plates is available. On the day of audit, meals were observed to be hot and well-presented and residents stated that they were enjoying their meal. There is a kitchen manual and a range of

and nutritional needs are met where this service is a component of service delivery.		policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures were monitored and recorded daily. Food temperatures are checked, and these were all within safe limits. The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes were noted in a folder. The eight-weekly menu cycle is approved by the contracted company's dietitian. The last satisfaction survey showed some dissatisfaction with the food. The facility and the contracted company are working together to improve this. Residents and family members interviewed were satisfied with the meals. There are jugs of fluid in each resident's room and water coolers in communal areas. Staff were observed to be assisting residents with their meals and ensuring resident safety and supervision as needed when providing hot drinks. The food control plan expires on 2 July 2019.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	When a resident's condition changes the registered nurse initiates a GP/NP consultation. Staff stated that they notify family members about any changes in their relative's health status. All care plans sampled had interventions documented to meet the needs of the resident. Care plans have been updated as residents' needs changed. Resident falls are reported in VCare and written in the progress notes. Neurological observations are completed for unwitnessed falls or falls where residents hit their heads. Family are notified. Care staff interviewed stated there are adequate clinical supplies and equipment provided including continence and wound care supplies. Wound assessment, wound management and evaluation forms are in place for all wounds. Wound monitoring occurs as planned. RNs are alerted to wound dressing changes by a daily VCare calendar. There are currently twenty minor wounds being treated (category A and B skin tears and skin abrasions). There are five pressure injuries, four stage 1 and one stage 2. One pressure injury is infected and the GP charted antibiotics for this. There are also photos to show wound progress. All wound documentation was fully completed. Monitoring forms are in use as applicable such as weight, vital signs, repositioning, neurological observations, pain, restraint and wounds. Behaviour charts are available for any residents that exhibit challenging behaviours. Monitoring charts were completed for at risk residents that require increased monitoring. All residents are checked at least 2-hourly.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a	FA	There is one diversional therapist who works 30 hours a week Sunday to Thursday. There is one recreational officer (training to become a diversional therapist) who works 30 hours a week Tuesday to Saturday. On the days of audit residents were observed listening to a newspaper reading, doing chair yoga and playing Koala Keno. In the afternoon there was a sundae social. There is a weekly programme in large print on noticeboards and residents also have a copy in their rooms.

consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.		Residents have the choice of a variety of activities in which to participate, and every effort is made to ensure activities are meaningful and tailored to residents' needs. These include exercises, games, quizzes, music and walks outside. Those residents who prefer to stay in their room or who need individual attention have one-on-one visits to check if there is anything they need and to have a chat. Volunteer ex-nurses form the village assist with one-on-one activities for residents with memory loss or those who chose to stay in their rooms. There is an Anglican Church service every second Wednesday, a Baptist service every first Thursday and a Catholic service on the last Tuesday. Some residents go out to their church. There are weekly van outings and every fourth outing the residents have morning tea or lunch out. There are regular entertainers visiting the facility. Special events like birthdays, Easter, Fathers' Day, Anzac Day and Valentine's day are celebrated. There is pet therapy monthly. There is community input from volunteers, schools, Plunket (mothers and babies visit) day cares and Kapa Haka groups. Some residents go to Age Concern and some to morning/afternoon teas at the Anglican Church. Residents have an activity assessment completed over the first few weeks following admission that describes the residents past hobbies and present interests, career and family. Resident files reviewed identified that the activity plan is based on this assessment. Activity plans are evaluated at least six monthly at the same time as the review of the long-term care plan. Resident meetings are held monthly. There is also a 'friends of family' meeting three monthly taken by an independent advocate. The recent satisfaction survey identified there were not enough activities for residents with cognitive impairment. The service developed an action plan to implement small group activities for residents with memory loss. Residents interviewed on the day of audit were satisfied with the activities offered. On the days covered by two members of the team there are activities in the lounge and also sensory activities in the smaller lounge for residents with cognitive impairment. They are also commencing music and art groups.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	The five long-term care plans reviewed had been evaluated by the registered nurses six monthly or when changes to care occurs. The short-term care plans for short-term needs are evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. Activities plans are in place for each of the residents and these were also evaluated six monthly. The multidisciplinary review involves the RN, GP/NP and resident/family if they wish to attend. There are three monthly reviews by the GP/NP for all residents. The family members interviewed confirmed that they are informed of any changes to the care plan.
Standard 1.4.2:	FA	The building has two levels. The ground level has the village café and serviced apartments. The care centre is located on the first level with a covered air-bridge to the first-floor serviced apartments, there are two lifts and

Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.		stairwells linking to the ground floor, there are rest home level residents on both floors of the serviced apartments. The building has a current building warrant of fitness that expires 14 December 2019. Two rooms in the care centre were assessed as suitable for use as a double room for couples. There were calls bells accessible in the room and ensuite. There was sufficient space to deliver safe care to rest home or hospital level residents. Planned and reactive maintenance systems are in place and maintenance requests are generated through the on-line system (property services requests). There are regular maintenance checks of resident related equipment. Recent purchases include sensor mats and new bedrails. The facility was well maintained and clean including resident rooms and ensuites. There was an adequate supply of towels and facecloths in ensuites. No soiled linen was sighted in rooms. Residents and relatives interviewed stated they were happy with the housekeeping and laundry services and cleanliness of their rooms. The day of audit was very warm, however the temperature inside the facility was comfortable. There were air conditioning units and standing fans in communal areas and corridors. There were residents with fans going in their room. To date there were seven resident rooms that had air conditioning installed that is controlled from a central point. The facility is participating in a pilot scheme/action plan for extreme temperatures.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	Click here to enter text
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance	FA	The infection control policy includes a surveillance policy including a surveillance procedure, process for detection of infection, infections under surveillance, outbreaks and quality and risk management. Infection events are collected monthly and entered onto the VCare electronic system. The infection control coordinator (RN) provides infection control data, trends and relevant information to the infection control committee and clinical/quality meetings. Areas for improvement are identified, and corrective actions are developed and followed up. The facility is benchmarked against other Summerset facilities of similar size and benchmarking results are fed back to the infection control

with agreed objectives, priorities, and methods that have been specified in the infection control programme.		coordinator and used to identify areas for improvement. Infection control audits are completed, and corrective actions are signed off. Surveillance results are used to identify infection control activities and education needs within the facility. Meeting minutes and infection rates are graphed and displayed for staff. There have been no outbreaks.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	There are policies (reviewed August 2018) around restraints and enablers which are known to staff. On the day of audit there were three residents using enablers and five residents with restraint. All residents were hospital level of care. Three files of residents using an enabler were reviewed and indicated that the enablers were based on the residents' voluntarily requesting to have the bedrails put into place for the purposes of safety and mobility in bed. The care plans described the enabler use and risks associated with the use of the bedrail enablers. All bedrails are checked regularly as part of the maintenance plan and there is a reporting system for any equipment that requires repair. The restraint coordinator is a RN supported by the clinical nurse manager. There are monthly restraint committee meetings and minutes are available to staff. Staff receive mandatory training around restraint minimisation that includes annual competency assessments. Care staff interviewed could describe the definition of an enabler and a restraint.

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.

No data to display

End of the report.