# Summerset Care Limited - Summerset down the Lane

## 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 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

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: 28 July 2020 End date: 29 July 2020

**Proposed changes to current services (if any):**

**Total beds occupied across all premises included in the audit on the first day of the audit:** 55

# 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 |
|  | 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 provides rest home and hospital level care for up to 51 residents in the care centre and up to 15 rest home residents in the serviced apartments. On the day of the audit there were 55 residents including 9 rest home residents in the serviced apartments. The residents and relatives interviewed spoke highly of the service and care provided at Summerset Down the Lane.

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, staff, general practitioner and other allied health professionals involved in the care of the residents.

The village manager is appropriately qualified and is supported by an experienced care centre manager and clinical nurse manager (registered nurse) who oversees the care centre and rest home residents in the serviced apartments. There are quality systems and processes being implemented. The service is focused on improving resident outcomes.

The service is commended for achieving three continuous improvement ratings around good practice, reduction of falls and activities.

## Consumer rights

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

Policies are documented to support resident rights. Systems protect their physical privacy and promote their independence. There is a documented Māori health plan in place which acknowledges the principles of the Treaty of Waitangi. Individual care plans include reference to residents’ values and beliefs.

Residents and relatives are kept up-to-date when changes occur or when an incident occurs. Systems are in place to ensure residents are provided with appropriate information to assist them to make informed choices and give informed consent.

A complaints policy is documented that aligns with the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). A complaints register is maintained.

Consents are documented by residents or family and there are advance directives documented if the resident is competent to complete these.

## 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. |

Organisational performance is monitored through several processes to ensure it aligns with the identified values, scope, and strategic direction. The business plan is tailored to reflect the goals related to Summerset Down the Lane. There are policies and procedures to provide appropriate support and care to residents with hospital and rest home level needs. This includes a documented quality and risk management programme that includes analysis of data. Meetings are held at regular intervals to discuss quality and risk management and to ensure these are further embedded into practice. There is a health and safety management programme that is implemented with evidence that issues are addressed in a timely manner.

An orientation programme is in place and there is ongoing training provided as per the training plan developed for 2020. Rosters and interviews indicate sufficient staff that are appropriately skilled, with flexibility of staffing around clients’ needs. A roster provides sufficient and appropriate coverage for the effective delivery of care and support including planned staffing for the rest home residents in serviced apartments. Registered nursing cover is provided twenty-four hours a day, seven days a week.

The residents’ files are appropriate to the service type.

## Continuum of service delivery

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

Residents are assessed prior to entry to the service and an initial assessment is completed upon admission. Registered nurses are responsible for care plan development with input from residents and family. Long-term care plans and interRAI assessments reviewed were completed within required timeframes. Residents and family interviewed confirmed that the care plans are consistent with meeting residents' needs. Planned activities are appropriate to the resident’s assessed needs and abilities and residents advised satisfaction with the activities programme.

Medications are managed and administered in line with legislation and current regulations. General practitioners review medication charts three monthly.

Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

## 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. |

Summerset Down the Lane has a current building warrant of fitness. Reactive and preventative maintenance is carried out. Chemicals are stored securely and staff are provided with personal protective equipment. Hot water temperatures are monitored and recorded. Medical equipment and electrical appliances have been calibrated. Residents’ rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. There are sufficient communal areas within the facility including lounge, dining areas and outdoor gardens and grounds. There is a designated laundry and cleaners’ rooms. Documented systems are in place for essential, emergency and security services in the care centre and for serviced apartments. Call bells are in all resident areas with residents stating that these are answered in a timely manner. There is a staff member on duty always with a current first aid certificate. External garden areas are accessible with suitable pathways, seating and shade.

## Restraint minimisation and safe practice

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

Restraint minimisation and safe practice policies are in place to guide staff in the use of an approved enabler and/or restraint. On the day of audit there were no residents using restraint or enablers. Staff training has been provided around restraint minimisation and management of challenging behaviours. The restraint coordinator, clinical nurse manager and staff have worked to identify individual strategies for residents other than using bedrails.

## Infection prevention and control

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| --- | --- | --- |
| 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 is appropriate for the size and complexity of the service. The infection control coordinator (RN) is responsible for coordinating and providing education and training for staff. The infection control manual outlined the scope of the programme and included a comprehensive range of policies and guidelines. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This included audits of the facility, hand hygiene and surveillance of infection control events and infections. 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** | 2 | 43 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 3 | 90 | 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | The Health and Disability Commissioner’s (HDC) Code of Health and Disability Consumers’ Rights (the Code) brochures are accessible to residents and their families. Policy relating to the Code is implemented and staff interviewed (nine caregivers, three registered nurses (RN), one recreational therapist, one diversional therapist, one property manager, four managers, one cleaner, one laundry staff) could describe how the Code is incorporated into their everyday delivery of care. Staff receive training about the Code during their induction to the service, which continues annually through the staff education and training programme.  Two external providers including the clinical nurse specialist from the DHB Post-Acute Care team (PAC), the Hospice clinical nurse specialist/ARRC liaison nurse and three contractors including a physiotherapist, kitchen manager and food services manager all stated that staff at the service focused on ensuring that resident rights are upheld. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Informed consent for release of medical information, photograph and outings were present in eight resident electronic files reviewed (four rest home including one resident in the serviced apartments and one resident under PAC funding and four hospital level of care residents). Permission granted are also included in the admission agreement. Resuscitation forms are completed by the competent resident. The GP makes a medically indicated not for resuscitation decision in consultation with the family for the incompetent resident. Advance care planning discussions with families and the resident commence on admission as part of the palliative care approach. Residents interviewed confirmed that information was provided to enable informed choices and that they were able to decline or withdraw their consent. Resident admission agreements were signed. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Information on advocacy services is included in the resident information pack that is provided to new residents and their family on admission. Advocacy brochures are also available at reception. Interviews with residents and family confirmed their understanding of the availability of advocacy services.  An advocate from the nationwide Health and Disability Advocacy Service attends the family meetings. Staff can name the advocate and stated that they understand the role of the advocate.  The complaints process is linked to advocacy services with this offered to any complainant if required.  Staff receive regular education and training on the role of advocacy services, which begins during their induction to the service with training records confirming this. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | The service has an open visiting policy. Residents may have visitors of their choice at any time and family interviewed confirmed that they can visit whenever they like. The main doors lock automatically at dusk and independent residents hold a swipe card to enter the building after doors are locked. Family are able to ring through to the RN if they wish to visit after hours.  The service encourages the residents to maintain their relationships with their friends and community groups. Assistance is provided by the care staff to ensure that the residents participate in as much as they can safely and desire to do as observed during the audit. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | 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 care centre manager is responsible at this facility for addressing any complaints in consultation with the village manager.  A complaints procedure is provided to residents within the information pack at entry. Feedback forms are available for residents/family members in various places around the facility. There is a complaints’ register that includes relevant information regarding the complaint. There have been two formal complaints lodged in 2020. Both were reviewed and this confirmed that complaints are responded to in a timely manner as per policy with each complainant confirming that they were happy with the outcome.  Residents and family interviewed stated that they felt they could complain at any time and those that had stated that their concerns had been dealt with in a timely manner to their satisfaction. They also stated that the new managers were ‘extremely competent and visible’ which allowed for discussion and encouraged any concerns to be raised.  A report has been received by Summerset Down the Lane in June 2020 from the Health and Disability Commission. The letter is in response to a complaint lodged with the Health and Disability Commissioner in 2017. The letter identified an action plan with this currently being addressed as per timeframes documented in the letter. There have not been any other complaints from external providers since then. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Details relating to the Code and the Health and Disability Advocacy Service are included in the resident information folder that is provided to new residents and their families. On admission an RN discusses aspects of the Code with residents and their family on admission.  Discussions relating to the Code are also held during the monthly resident and three-monthly family meetings. Nine residents interviewed (six rest home including one in a serviced apartment, and three requiring hospital level care) confirmed that they received cares that met their needs, and all were aware of their rights. Six family members interviewed (two rest home and four with family requiring hospital level care) confirmed that staff had informed them of the Code. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | The residents’ personal belongings are used to decorate their rooms. Rooms have ensuites and there are communal toilets as well. All have locks to ensure privacy.  The caregivers interviewed reported that they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas. This was observed to occur during the audit. Caregivers reported that they promote the residents' independence by encouraging them to be as active as possible. All the residents and families interviewed confirmed that residents’ privacy is respected.  Guidelines on abuse and neglect are documented in policy. Staff receive annual education and training on abuse and neglect, which begins during their induction to the service. Incidents were reviewed for 2020 and there are no incidents around abuse. Staff, the general practitioner and two external providers interviewed confirmed that there was no evidence of abuse or neglect.  There are spiritual services and residents are encouraged to attend their own spiritual care in the community. There is at least one church service a week both in the upstairs area and downstairs. Any resident or family member can attend. Spiritual needs are individually identified as part of the assessment and care planning process. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  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. | FA | The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. The care staff interviewed reported that they value and encourage active participation and input from the family/whānau in the day-to-day care of the resident. There are two residents living at the facility who identify as Māori and both were assessed for cultural needs with any plans documented in the care plan.  Māori consultation is available through links with Māori organisations within the Summerset community including a village resident (kaumātua) who identifies as Māori and who can provide advice and support if required. Staff receive annual education on cultural awareness that begins during their induction to the service.  There is a Māori health plan with goals to improve outcomes for residents. This is dated 2020-2022 and included input from an external Māori consultant. The service can also access support through the Māori Health Unit at the district health board if required. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | The service identifies the residents’ personal needs and desires from the time of admission. This is achieved in collaboration with the resident, family and/or their representative. Staff interviewed confirmed that they are committed to ensuring each resident remains a person, even in a state of decline. Beliefs and values are discussed and incorporated into the care plan as sighted in the review of eight resident records reviewed (three rest home and three hospital). Residents and families interviewed confirmed they are involved in developing the resident’s plan of care, which includes the identification of individual values and beliefs. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | There are implemented policies and procedures to protect clients from abuse, including discrimination, coercion, harassment, and exploitation, along with actions to be taken if there is inappropriate or unlawful conduct. Expected staff practice is outlined in job descriptions. Staff interviewed demonstrated an awareness of the importance of maintaining professional boundaries with residents.  Residents interviewed stated that they have not experienced any discrimination, coercion, bullying, sexual harassment, or financial exploitation. Professional boundaries are reconfirmed through education and training sessions, staff meetings, and managers stated that performance management would address any concerns if there was discrimination noted. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | CI | The service meets the individualised needs of residents who have been assessed as requiring rest home or hospital level care as identified through interviews with care staff and through an audit of resident files.  The service has policies and procedures, equipment, and resources to support ongoing care of residents. The quality programme has been designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. Meetings are conducted to allow for timely discussion of service delivery and quality of service including health and safety.  Residents interviewed spoke very positively about the care and support provided. Both family and residents interviewed stated that the managers were very visible and encouraged open discussion at all times. Staff interviewed had a sound understanding of principles of aged care and stated that they are supported by the management team. Caregivers complete competencies relevant to their practice. Several of the RNs have taken on “champion” roles and attend relevant external education to support them in their role such as wound care champion, palliative care champion, continence champion, falls champion and challenging behaviour champion.  The general practitioner interviewed is satisfied with the care that is being provided by the service. The nurse practitioner was a trained palliative care nurse and the GP stated that the service supports residents requiring palliative care with a high quality of care relevant to their needs. The service has been awarded a continuous improvement rating for their continuing commitment to palliative care and support for residents and families. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents interviewed, confirmed they were given an explanation about the services and procedures and were orientated to the facility as part of the entry process. They also stated their relatives are informed of changes in health status and incidents/accidents with family interviewed confirming that they were kept informed at all times. A review of 15 incident forms confirmed that family were informed in a timely manner when incidents occurred. Family interviewed also confirmed they were informed at all times.  Resident meetings have occurred monthly and there are family meetings three monthly. Residents and family confirmed that they find the meetings useful and provide opportunities to raise issues or concerns. Residents and family interviewed confirmed that the care centre manager, clinical nurse manager and the village manager have an open-door policy. The regional quality manager interviewed also stated that the managers discuss how they can improve resident outcomes on a regular basis.  Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The service has policies and procedures available for access to interpreter services for residents (and their family). If residents or family/whānau have difficulty with written or spoken English, the interpreter services are made available through the district health board with phone numbers identified in policy. There are staff on site who speak a range of languages including te reo Māori. The clinical nurse manager stated that if a resident enters the service with a language that staff also speak, then that staff would be allocated to support the resident. There are no residents currently requiring the use of interpreting 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(medical and geriatric) levels of care in their care facility for up to 51 residents (includes two double rooms in the care centre). There are 50 serviced apartments which are verified as suitable for residents requiring rest home level of care noting that a maximum of 15 for residents requiring rest home level of care can be used at any given time. On the day of the audit there were 55 residents requiring hospital or rest home level of care. There were 25 at rest home level including nine in the serviced apartments; and 30 at hospital level. One resident is using respite care through Post-Acute Convalescent funding from the district health board and all others are funded through the Age-Related Care Contract. All residents’ rooms in the care facility are identified as dual-purpose.  A village manager (VM) is responsible for the retirement village. The VM was appointed in August 2018 and have 18 years of non-clinical experience within the aged care industry. She is supported by a care centre manager (registered nurse with no current annual practicing certificate) who has 30 years health management experience with relevant training and who has been in the role for over three years. The clinical nurse manager is a registered nurse who was appointed to the role three months prior to the audit. She has worked in rehabilitation services for two years with a 10-year background in nursing overseas.  Summerset group has a well-established organisational structure. Each of the Summerset facilities throughout New Zealand is supported by this structure. The regional quality manager supported the team on the day of audit and there are managers meetings weekly. The Summerset group has a comprehensive suite of policies and procedures, which guides staff in the provision of care and services. The Summerset Group Limited Board of Directors have overall financial and governance responsibility and there is a company strategic business plan in place. Summerset Down the Lane has a site-specific 2020 business plan and goals that is developed in consultation with the village manager, care centre manager and regional quality manager. There is a full evaluation completed at the end of the year with a quarterly review of progress documented against goals. The philosophy, vision and values of the organisation are documented and able to be articulated by staff when interviewed.  The managers had all attended at least eight hours of leadership professional development and/or clinical training relevant to the role. |
| Standard 1.2.2: Service Management  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 safe services to consumers. | FA | The village manager is responsible for the administrative functions of the facility and the care centre manager is responsible for operational management of the service. The clinical nurse manager provides oversight of clinical care. The office manager would work with the care centre manager to relieve for the village manager if they were on leave and the village manager would relieve for the care centre manager when away. |
| 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 | There is an established quality and risk management system. 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 quality assurance framework 2020 calendar. The calendar schedules the training, meetings, and audit requirements for the month.  The annual residents/relatives survey for the service was last completed in August 2019. There was an 85% response rate from residents and family. The service received 96.9% satisfaction with the Summerset average at 96.4% overall satisfaction. The survey results showed a marked improvement from 2018 when the overall satisfaction was rated at 88% (53% response rate).  There is a meeting schedule that includes monthly meetings as follows: quality improvement; caregiver; registered nurse; activities; and resident meetings. There are three monthly family meetings. There is a monthly care staff meeting that includes discussion about clinical indicators (eg, incident trends, infection rates). Health and safety, infection control and restraint meetings have occurred monthly. There is also a weekly management meeting.  The service is implementing an internal audit programme that includes aspects of clinical care. Issues arising from internal audits are developed into corrective action plans with evidence of resolution of issues as these are identified. Monthly and annual analysis of results is completed and provided across the organisation. There are monthly accident/incident benchmarking reports completed by the care centre manager that break down the data collected across the rest home and hospital with this compared to other Summerset services of similar size and composition. Infection control is also included as part of benchmarking across the organisation. Health and safety internal audits are completed.  Summerset’s clinical and quality managers analyse data collected via the monthly reports and corrective actions are required based on benchmarking outcomes. There is a health and safety and risk management programme in place including policies to guide practice. There is a health and safety plan with evidence of review at the health and safety meetings. There are health and safety representatives. The service addresses health and safety by recording hazards and near misses, sharing of health and safety information and actively encourage staff input and feedback. The service ensures that all new staff and any contractors are inducted to the health and safety programme with a health and safety competency completed by staff as part of orientation (staff records confirmed that these had been completed).  Falls prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. The service has received a continuous improvement rating for achieving a marked reduction in resident falls with injury. |
| 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 is being collected and analysed. A review of 15 incident/accident forms that occurred in June or July 2020 identified they were all fully completed, including follow-up by a registered nurse and that family had been notified. Post-falls assessments included neurological observations for 12 unwitnessed falls were completed as per policy. Near misses are also reported through the incident reporting system.  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 used for comparative purposes. Discussions with the management team confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Section 31 notifications are completed as required and since the last audit, there has been one around the appointment of the clinical nurse manager and three for pressure injuries. |
| 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 | There are human resources policies to support recruitment practices. Nine staff files (one care centre manager, three registered nurses, three caregivers, housekeeper and one diversional therapist (one of whom is also working as a recreational therapist) were reviewed and all had relevant documentation relating to employment.  Performance appraisals have been completed annually. Copies of annual practising certificates are on file and a review confirmed that these were current including RNs and external providers requiring these.  The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and believed new staff were orientated well to the service. The orientation programme includes a buddy system with the new staff member working alongside an experienced care staff member for five days. Care staff complete competencies as part of orientation relevant to their role. One new staff interviewed confirmed that they had a relevant and comprehensive orientation.  There is an annual education plan in place. The 2020 education plan is being implemented and staff stated that this is relevant to their role. A competency programme is in place with different requirements according to work type (eg, caregivers, RNs, and kitchen). Core competencies are completed, with a record of completion maintained. Staff interviewed were aware of the requirement to complete competency training. The service has six RNs (including the clinical nurse manager) trained in interRAI. RNs complete online learning through Ko Awatea.  There are 36 caregivers. Caregivers have completed Careerforce training as follows: eight who have completed level four; six have completed level three; 15 have completed level two training.  Staff attrition has dropped significantly over the past 18 months. There have not been any RN resignations in 18 months. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | Staffing levels and skills mix policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery. There are clear guidelines for increase in staffing depending on acuity of residents. A staff availability list ensures that staff sickness and vacant shifts are covered, and a review of rosters for the past three months confirmed that staff are replaced when on leave.  Interviews with residents and relatives confirmed that staffing levels are sufficient to meet the needs of residents. The village manager, care centre manager and clinical nurse manager all work 40 hours per week from Monday to Friday and are available on call for any emergency issues or clinical support. The service provides 24-hour RN cover with two RNs on the morning and afternoon shifts and one overnight.  In the care centre, there are RNs and caregivers rostered. There are eight caregivers (three long and five short shift) on duty in the morning shift; seven caregivers (three long and four short shift) on duty in the afternoon and two caregivers (long shift) on duty in the night shift.  There are four wings identified (green, pink, blue and orange) with 10 to 12 residents in each wing. Staff are designated to each wing and caregivers stated that they always work in pairs with a ‘floater’ working in orange wing able to support when required. This ensures that staff are able to support residents who are lifted using a hoist with two staff at all times.  In the serviced apartments there are one or two caregivers on duty in the morning and afternoon shifts, and one on the night shift.  The clinical nurse manager and the care centre manager are on call after hours. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The residents’ files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24-hours of entry into each resident’s individual record. An initial support plan is also developed in this time. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents’ files are protected from unauthorised access by being held in a secure room. Archived records are secure in separate locked areas.  Residents’ files demonstrated service integration. Entries are legible, dated, timed, and signed by the relevant caregiver or nurse, including designation. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | The service has admission policies and processes in place. Residents receive an information booklet around admission processes and entry to the service. The clinical manager screens all potential residents prior to entry to services to confirm they meet the level of care provided at the facility. Residents and relatives interviewed confirmed they received information prior to admission and discussed the admission process and admission agreement with the village manager/care centre manager. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | The transfer/discharge/exit procedures include a transfer/discharge record which is kept on the resident electronic file. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. Relatives are notified if transfers occur as sighted in one resident file where the resident was transferred to hospital following a fall. |
| 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 | The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management. All medicines are stored securely in the care centre. Registered nurses, the enrolled nurse and senior caregiver’s complete annual medication competencies and medication education. The RNs complete a syringe driver competency. Medications for rest home residents in serviced apartments are stored in the care centre and administered by the RN on duty.  Medication reconciliation occurs against the robotic rolls on delivery and recorded in the electronic medication system. ‘As required’ medications are checked for expiry dates monthly. Hospital level stock medications are checked monthly for expiry dates and stock levels. The medication fridge temperature and medication room temperature are being monitored daily and both were within acceptable limits. All eye drops were dated on opening. There were four rest home residents self-administering who had self-medication competency completed and reviewed three monthly. Medications were stored in locked drawers in their rooms.  Fifteen medication charts on the electronic medication system were reviewed. One paper-based medication script was reviewed for the PAC funded resident. All charts had photo identification and allergy status documented. The effectiveness of ‘as required’ medications were recorded in the electronic medication system and the electronic progress notes. All long-term medications charts had been reviewed by the GP 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 company is contracted for the provision of meals on site and café service. The owner/contractor (interviewed) is a qualified chef. There is a kitchen manager (interviewed), second cook and dishwasher (morning and afternoon) on duty each day. Food services staff receive orientation and ongoing food safety training. There is an eight-week rotating menu approved by a registered dietitian in May 2020. Resident dislikes and allergies are known and accommodated. Special diets including gluten free, dairy free and pureed meals are provided. The kitchen manager receives a dietary profile for each resident and is notified of any changes to residents’ dietary requirements. Meals are plated and delivered by hot box to the serviced apartment dining room. Meals are served from a bain marie in the care centre satellite kitchen which is fully functional.  The verified food control plan expires July 2021. The service uses a computer-based food control plan to record all daily temperatures for fridge, freezer, chiller, end-cooked and meal service food temperatures, inward goods and dishwasher temperatures. The chemical provider completes a monthly dishwasher service including effectiveness of chemical use. All foods were dated. Staff were observed wearing correct personal protective clothing.  The kitchen manager attends resident meetings for feedback and input into the meals. Resident surveys allow the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed were very satisfied with the food service. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | The service records the reason for declining service entry to potential residents should this occur and communicates this to potential residents/family/whānau. Anyone declined entry is referred back to the needs assessors or referring agency for appropriate placement and advice. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | All appropriate personal needs information is gathered during admission from medical records, hospital discharge summaries, allied health notes and information from the resident (as appropriate) and family. Risk assessments for example falls, skin and pressure injury, pain, mobility, nutritional and behaviour are completed on admission with outcomes reflected in the initial care plan. An interRAI assessment is completed within three weeks of admission and triggers and outcomes are reflected in the long-term care plan. Assessments are completed as part of the six-monthly evaluation or with any health changes. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The long-term care plan (which is electronic) includes nursing diagnosis, actual or potential deficits, outlined objectives of nursing care, setting goals, and details of implementation. Care plans developed by the enrolled nurse had been countersigned by an RN. Resident/family/whānau involvement in the care planning process was evident. Residents and relatives interviewed and resident files reviewed confirmed that resident/family were involved in the development/evaluation of care plans. Short-term care plans were in use for changes in health status including weight management, wounds, falls and infections. InterRAI triggers and outcomes were linked to the care plans. Involvement of allied health professionals in resident care were linked to the long-term care plan. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | A record of each resident’s progress is documented in electronic notes. Changes are followed up by a registered nurse. When a resident's condition alters, the registered nurse initiates a review and if required, a GP or NP consultation or referral to the appropriate health professional. Relatives interviewed during the audit confirmed they are notified of any changes to the resident’s health status.  Dressing supplies are available. Wound documentation was reviewed and included wound assessment, wound plans, short-term care plans and evaluations. Photos were taken as relevant. Twelve of 19 wounds were reviewed and included two chronic ankle ulcers, one stage two pressure injury of toe (rest home resident) and 10 skin tears. Referrals were made to the DHB wound care nurse for complex wounds. There is an RN wound care nurse at the service who reviews wounds and provides support for RNs. She has received wound care training.  Continence products were available and specialist continence advice is available as needed. There is an RN continence nurse at the service who reviews continence assessments, reviews residents and provides support for RNs. She has received continence management training.  Monitoring forms are used to monitor a resident’s progress and response to interventions including bowel charts, blood pressure, pulse, temperature and respirations, blood sugar levels, pain monitoring, weights, food and fluid, fluid input and output charts, turning charts, behaviour charts and neurological observations. |
| 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. | CI | The activities staff (a qualified diversional therapist (DT) and one recreational therapist (RT) who has just completed DT training) provide an activities programme over seven days each week. The DT works Sunday to Thursday 9.30 am – 4 pm and the RT works Tuesday to Saturday 9.30 am – 4 pm. There are three days a week where the two staff are on duty together with one working 10.30 am – 5 pm on those days. This has allowed for a choice and variety of activities including sensory activities for residents with memory loss. The service has been successful in implementing a memory care group, several activity therapies and community links which has increased resident participation and satisfaction with the activity programme.  The programme is planned monthly and residents receive a personal copy of planned monthly activities. Activities plans for the month are displayed in large style colour format on notice boards around the facility. Activities are held in the lounge, dining room or conservatory and are appropriate and meaningful for the residents. Activities include newspaper reading, exercises, variety of quizzes and brain teasers, board games, indoor bowls, music, movies, happy hour and group walks around the village and gardens. Residents were observed participating in activities on the days of audit. There are regular entertainers, church services and outings to community events, cafés and scenic drives. The service has a van that is used for resident outings.  The rest home residents in the serviced apartments may choose to attend either the care centre activities or the serviced apartment activity programme. Daily contact is made with residents for short-term. Residents who are unable to or choose not to participate have one-on-one time for individual activities.  A diversional therapy plan is developed for each individual resident based on assessed needs. A 24-hour activity plan is developed for residents with memory loss/challenging behaviours. The DT and RT attend the six-monthly MDT meetings and the activity plan is evaluated at the same time as the care plan. Resident meetings (monthly) provide a forum for residents to feedback on activities. Residents and family members interviewed discussed enjoyment in the programme and the diversity offered to all residents. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Long-term care plans reviewed were updated as changes were noted in care requirements. The PAC residents initial care plan had been updated with changes to care. Six monthly multidisciplinary team meetings were held with the RN, DT, residents (as appropriate) and family member. The family member is invited to attend the MDT and if unable to attend are involved in the care plan evaluation through phone or email discussion. Input is sought from allied health professionals involved in the care of the resident. Written care plan evaluations record if the resident goals have been met or unmet. Short-term care plans are utilised for residents and regularly reviewed, resolved or added to the long-term care plan if an ongoing problem. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | The service facilitates access to other services (medical and non-medical) and where access occurred, referral documentation is maintained. Residents and or their family/whānau are involved as appropriate when referral to another service occurs. InterRAI assessments had been completed for significant change in health status requiring a re-assessment of level of care. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Safety data sheets were readily accessible for staff. Chemicals were stored safely throughout the facility. Chemical bottles sighted have correct manufacturer labels. A measured dispensing system is used for the re-filling of chemical bottles. Personal protective clothing is available for staff and seen to be worn by staff when carrying out their duties on the day of audit. Relevant staff have completed chemical safety training. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The care centre and serviced apartment building have a current warrant of fitness that expires on 4 December 2020. There is a full-time property manager who is available on call for urgent facility matters. The maintenance team include planned and reactive maintenance systems in place including a maintenance request book and a computer-based request system. All electrical equipment is on a schedule for testing and tagging, last completed September 2019. Clinical equipment has been calibrated and resident-related equipment such as hoists have had functional checks. Hot water temperatures in resident areas are tested monthly, with readings below 45 degrees Celsius. Preferred contractors are available 24/7.  Corridors are wide in all areas to allow residents to pass each other safely. There is safe access to all communal areas and outdoor areas. There is outdoor seating and shade. Room refurbishments are ongoing as part of the maintenance plan.  The caregivers and registered nurses (interviewed) stated they have all the equipment required to provide the care documented in the care plans. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  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. | FA | Visual inspection evidenced toilet and shower facilities are of an appropriate design to meet the needs of the residents. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. There are 47 rooms with full ensuites and two standard rooms with closely located shared bathroom and toilet facilities. There are communal toilets located near communal areas. Communal toilet and shower facilities have a system that indicates if it is engaged or vacant. Residents interviewed confirmed staff respected their privacy when attending to their personal cares. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | There are 49 resident rooms with two rooms certified as double rooms. The rooms are spacious with adequate room to safely manoeuvre mobility aids and transferring equipment such as hoists. The doors are wide enough for ambulance trolley access. Residents and families are encouraged to personalise their rooms as viewed on the day of audit. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There is a large lounge and dining room, a conservatory off the dining room and balcony garden area within the care part of the facility. The dining room is spacious and located directly off the kitchen/servery area. There are several seating alcoves located within the centre where quiet activities can take place or for visitors. All areas are easily accessible for the residents. Residents interviewed reported they were able to move around the facility and staff assisted them when required. Activities take place in the lounge or the conservatory. Rest home residents in the serviced apartments may dine in their rooms or the serviced apartment dining room. The village café and library are available to all residents. There is a playground for children who visit adjacent to the café which is a popular area for all residents to socialise. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. The laundry is located in the service area on the ground floor and operates from 7 am to 3 pm seven days a week. There is a clean/dirty workflow with an entry and exit door. The laundry bags from the care centre are delivered to the laundry by a chute in the care centre.  There are dedicated housekeeping staff throughout the facility. Cleaning trolleys are kept in designated locked cupboards when not in use. Housekeeping staff carry their caddy of cleaning chemicals into the room they are cleaning. Residents and family interviewed reported satisfaction with the cleaning and laundry service. Internal audits monitor the effectiveness of the cleaning and laundry processes. The chemical provider monitors the effectiveness of chemicals. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | There is an approved evacuation scheme. Evacuation drills occur at least six monthly with the results of these documented. All staff have completed education on emergency management. There is a staff member on duty 24/7 with a current first aid certificate.  In the event of an emergency, alternative energy and utility sources are available such as emergency lighting that lasts for approximately two hours, and spare batteries for lights; a gas barbecue and both gas and electricity for cooking; extra linen, continence products, water and blankets. Food dry stock and frozen food are available to support residents for at least three days. There is sufficient drinking water on site to support the maximum number of residents on site for at least seven days. There is a small generator on site and the service has access to a larger one located in Taupo.  An electric call bell system is available throughout the units. The call bells are monitored and residents stated that they are answered in a timely manner. Security is maintained. Staff on the afternoon and night shifts are responsible for ensuring the facilities doors and windows are closed appropriately and doors are locked appropriately. |
| 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 | Visual inspection evidenced that the residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. Additional air conditioning units have been recently installed in the care centre. |
| Standard 3.1: Infection control management  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. | FA | The infection control programme is appropriate for the size and complexity of the service. There is an infection control responsibility policy that includes responsibilities for the infection control officer. The infection control (RN) has been in the role since April 2020 and has a signed job description outlining the responsibilities of the role. The infection control programme is linked into the quality management system and reviewed annually at head office in consultation with the infection control committee. The facility meetings include a discussion of infection control matters.  Visitors are asked not to visit if they are unwell. All visitors including contractors are required to declare their wellbeing (implemented during COVID-19) when signing in on the electronic register. COVID-19 precaution notices and hand sanitizers are available at facility entrances. Influenza vaccines are offered to residents and staff. Hand sanitisers are available throughout the facility. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The infection control coordinator has completed orientation to the role and is being supported by the previous infection control coordinator. The infection control coordinator is allocated two hours per week to complete infection events and collate data. There are monthly “zoom” meetings with all organisational infection control coordinators and the Summerset infection control lead coordinator. The infection control committee comprises of a cross section of staff from areas of the service including housekeeping and kitchen services. The infection control team meet monthly and provide reports to head office and facility meetings.  The infection control team has access to an infection control nurse specialist at the DHB, laboratory, pharmacy, GPs and expertise within the organisation. The regional quality manager oversees infection control across the facilities. |
| Standard 3.3: Policies and procedures  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. | FA | Policies and procedures are developed and reviewed at head office in consultation with infection control coordinators. Policies are available to all staff. They are notified of any new/reviewed policies and are required to read and sign for these. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control coordinator is responsible for coordinating and providing education and training to staff. The induction package includes specific training around handwashing competencies and standard precautions. Ongoing training occurs annually as part of the training calendar set at head office. Registered nurses complete the infection control with Ko Awatea on-line learning. A Covid-19 resource folder was available with practical sessions provided on the correct use of personal protective clothing and isolation procedures.  Resident education occurs as part of providing daily cares. Care plans can include ways to assist staff in ensuring this occurs. |
| 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 surveillance policy includes a surveillance procedure, process for detection of infection, infections under surveillance, outbreaks and quality and risk management. Infection events are reported, collected monthly and entered into the electronic system. The infection control coordinator provides infection control data, trends and relevant information to the infection control committee and clinical/quality meetings. Meeting minutes are available to staff who read and sign the reading form. The facility is benchmarked against other Summerset facilities of similar size and benchmarking results are fed back to the infection control coordinator and used to identify areas for improvement. Improvements are identified and analysed with corrective actions developed and followed up. Additional education is provided at handovers where upward trends for infections have been identified. Reports and graphs are available in the staff room.  There have been no outbreaks. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. The use of restraint is a clinical decision made by the registered nurse in partnership with the GP. The GP completes the verification section on the specific consent form and also records a note in the medical continuation notes outlining the rationale for verifying or not verifying the use of restraint. The family will be involved in as many aspects of the decision as possible and their input recorded on the assessment form and in the progress notes by the RN. Family are not permitted to request restraint to be used unless there is clinical indication that supports the request.  This facility has been restraint-free since May 2020 resulting in a rating of continuous improvement. All incidents of behaviours that challenge are discussed in meetings. Alternatives are determined to avoid the use of restraint. The service has been awarded a rating of continuous improvement (link 1.2.3.6 and 1.3.7.1) for ratings of continuous improvement for their efforts in reducing the use of restraint in line with clear policies minimisation of restraint.  Residents can voluntarily request and consent to enabler use. The service has undertaken a comprehensive project to manage residents with challenging behaviour and/or falls. They have also reduced the use of restraint to zero from four using bedrails last in the first two quarters in 2020. This has been through a combination of reassessing residents and looking at other strategies to manage behaviour and falls. Two of the four residents who used bedrails as restraint had challenging behaviour (physical and verbal aggression) and both have now settled as a result of interventions around activities. They both are more settled when in bed. Two using restraint were assessed as a high falls risk and both have reduced the number of falls through the use of the chair alarm, hi-lo beds, sensor mats and exercise sessions. Staff training is provided around restraint minimisation and management of challenging behaviours on an annual basis. In the past, strategies to reduce or minimise the use of restraint have been minimal. Strategies have included use of low beds and bedrails. Strategies now in place include the use of sensor mats, hi-lo beds, air mattresses, regular toileting schemes implemented, hourly checks, and implementation of strategies used to prevent skin injuries, continence, and urinary tract infections. A review of multidisciplinary team meeting minutes for residents who in the past used restraint confirmed that they were very satisfied with the care provided. |

# 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.

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| 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.

|  |  |  |  |
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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 1.1.8.1  The service provides an environment that encourages good practice, which should include evidence-based practice. | CI | The service, with the support of the ARRC hospice clinical nurse specialist has strengthened their focus around palliative care through staff education, advance care planning, family and resident involvement and the implementation of palliative care assessment tools. | Over the last year the service has actively promoted a palliative approach in aged care. The hospice clinical nurse specialist (CNS)/ARRC liaison nurse (interviewed) role is resident focused and provides support and mentoring for RNs, the activity team and caregivers. The CNS has provided education covering the fundamentals of palliative care and additional sessions on pain management, assessment and early recognition of deteriorating health for those residents with life limiting conditions. The Supportive and Palliative Care Indicators tool (SPICT) – a tool developed by the university of Edinburgh, has been trialled and adopted by Hospice and Summerset. The assessment tool is now utilised on admission and for ongoing health changes. The service uses a traffic light system to identify a resident’s palliative care pathway, which is Green (more than six months of life) Amber (within the last six months of life) and Red (last days of life). The system is identified on the resident’s electronic care plan and on the resident whiteboard in the nurses’ station. The use of the assessment tool identifies early changes in a resident’s conditions prompting opportunities such as improving pain management that improves the resident’s quality of life. The resident and family are encouraged to be involved in care planning and decision making about their care ensuring their palliative care wishes are known and acted upon. The CNS meets with families and the RNs to encourage discussion and advance care planning. The diversional therapist and recreational therapist have incorporated a palliative care approach into their roles. The DT created a document “what is palliative care” and spends one-on-one time “heart-to-heart” sessions with residents which is allocated on the activity programme daily between 3 - 5 pm. The activity team hours were extended by an hour each day to enable quality time for “heart-to-heart” sessions. The service has also implemented Te Ara Whakapiri (last days of life) care plan. There is multidisciplinary input into the plan which is supported by the GPs. During the last days of life, a palliative extra-care package is made available to families which includes lovely bedding and pillowcases, diffusers, aromatherapy and moisturising lotions. Written compliments from bereaved families were sighted which included “excellent care and support”, “amazing, caring, incredible people”, “impressed with the level of empathy shown and the beautiful care”, “very grateful”, “dignity and grace”. |
| Criterion 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | CI | The service collects, analyses and evaluates falls data for opportunities for improvement. Falls prevention strategy included participation in an Auckland University research study for falls prevention based on exercise and muscle strength and balance. The service has been successful in reducing falls with injury over the past year. | Falls prevention strategies include falls risk assessments on admission, six monthly and as required due to falls or deteriorating condition. The physiotherapist (interviewed) completes initial mobility assessments on admission and for all residents, post falls or referral by the RN, GP or caregivers. The physiotherapist provides input into the six-monthly MDT. Fall prevention strategies are documented in care plans including the use of mobility aids, call bells within reach, uncluttered areas, safe footwear, family involvement, GP review of medications and excluding medical cause for falls, staff education, 24 hour activity plans, identifying time resident likely to fall and use of sensor mats and chair alarm. The physiotherapist is contracted by Auckland University to carry out twice weekly stand up and seating chair exercises for residents who are registered to attend. In July 2019 Summerset down the Lane was 14.8% higher than the national average and in December 2019 it was 7.7% higher than the national average. Over the last six months to May 2020 falls with injury are now 33% lower than the national Summerset average. |
| Criterion 1.3.7.1  Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | CI | In June 2019 the service identified an area for improvement around the activity programme following resident dissatisfaction with the activities offered. Efforts were directed toward popular meaningful activities. A memory group was initiated focusing on sensory activities. There has been community links established and integration between village, serviced apartment and care centre residents. The 2020 resident activity survey demonstrated an improved satisfaction in the activities offered. The facility has been accredited a dementia friendly village in 2020. | The service identified resident preferences around activities, community involvement and socialisation. Village walks were initiated with village and serviced apartment residents joining in which has helped break down the barriers for care residents. Several village residents volunteer with activities in the care centre. More coffee shop outings have been initiated for more independent residents who enjoy the opportunity to socialise outside of Summerset. Concurrent activity sessions have been implemented to meet the different cognitive abilities of residents. The memory group sessions of 5-10 residents focus on sensory activities including art, craft, music and pet therapy. Twenty-four-hour activity plans were developed for the residents with dementia/challenging behaviour focusing on triggers and interventions that are successful. The activity roster was adjusted to enable a presence in common areas and accommodate one-on-one time with residents. Challenging behaviours/wandering incidents have reduced to zero over the last two months. The service commenced an art therapy pilot project from March to August 2019 with the Arts for Community Health Trust. Residents provided very positive feedback (documented evidence) following monthly sessions with an art therapist. Residents experience a therapeutic process though a variety of arts including drawing related to memories/experience, sculpture work, model making and music. A community connection has been made with a charitable organisation that provides activities based on the Snoezelen model for residents with dementia and sensory loss. The DT and RT have attended training sessions and the residents visit their sensory room monthly. The residents visit children in a local childcare centre, participating in activities with the children such as reading and singing. The activity survey for February 2020 evidenced improvement in resident satisfaction with the programme with 60% excellent, 30% very good and 10% good. |

End of the report.