

# Summerset Care Limited - Summerset at Karaka

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## 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](#).

The specifics of this audit included:

**Legal entity:** Summerset Care Limited

**Premises audited:** Summerset at Karaka

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 21 July 2016 End date: 22 July 2016

**Proposed changes to current services (if any):** Construction is nearing completion for the addition of a new 19 bed wing on the first level of the care facility that is suitable for rest home and hospital levels of care. Furthermore, ten serviced apartments, suitable for rest home level of care will be opened on the ground level. Handover to operations is scheduled for 1 September 2016.

**Total beds occupied across all premises included in the audit on the first day of the audit: 33**



# Executive summary of the audit

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## 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 Karaka provides rest home and hospital level care for up to 31 residents in the care centre and rest home level care across 10 serviced apartments. On the day of the audit there were 29 residents in the care centre and four rest home residents in serviced apartments.

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 and a general practitioner.

A partial provisional was also completed as part of this audit to assess a newly built 19 bed wing on the first level of the care facility. The wing has been assessed as suitable to provide dual-purpose beds (rest home and hospital levels of care). Furthermore, 10 serviced apartments opened on the ground level were verified as suitable to provide rest home level of care. With the increase in beds, the service will be able to provide care for rest home/hospital level care for up to 50 residents in the care centre and 20 rest home residents in serviced apartments.

The village manager is appropriately qualified and experienced and is supported by a relieving nurse manager (registered nurse) who oversees the care centre. An induction programme is in place to provide staff with appropriate knowledge and skills to deliver care. The residents and relatives interviewed spoke positively about the care and support provided.

This certification audit identified areas for improvement around; recruitment documentation, care plans interventions, and restraint minimisation and safe practice documentation. Improvements required in relation to the partial provisional were around the completion and opening of the new wings.

## 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.
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Staff at Summerset at Karaka strive to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner's Code of Consumers' Rights. Cultural needs of residents are met. Policies are implemented to support residents' rights, communication and complaints management. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns have been managed and a complaints register is maintained.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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The quality and risk management programme includes service philosophy, goals and a quality planner. Quality activities are conducted and this generates improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes. There is a health and safety management programme available to guide staff. Residents/family meetings have been held. Incidents and accidents are reported. An education and training programme has been implemented with a current training plan in place. Appropriate human resources management policies are available. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

Partial Provisional:

A transition plan outlines the actions that are required to be completed prior to the scheduled opening. This plan is regularly updated. The general orientation programme is for a maximum period of three months although the interim clinical manager reported that they make every effort to complete new staff orientation within three weeks. A transitional safe staffing matrix has been developed to ensure staff numbers are adequate to meet the needs of the additional numbers of residents.

## Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The service has assessment and entry processes in place. There is a well-developed information pack available for residents and families/whānau at entry. The registered nurses are responsible for each stage of provision. Initial assessments and risk assessments, resident centred care plans and evaluations were completed within the required timeframes. Resident centred care plans were individualised and demonstrated allied health involvement in resident care.

A diversional therapist coordinates and implements an integrated activity programme over seven days. She is supported by a part-time recreational assistant. The activities meet the individual recreational needs and preferences of the residents. There are outings into the community and visiting entertainers.

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

The food service is contracted to an external company. Resident's individual dietary needs were identified and accommodated. Staff have attended food safety and hygiene training.

Partial Provisional:

There is one existing medication room for the care facility. This treatment room will service the new wing upstairs and all of the serviced apartments downstairs. Medications for rest home residents in serviced apartments are transported downstairs in the medication trolley for medication administration. There is a downstairs dining area for rest home level residents living in serviced apartments.

## 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.		Some standards applicable to this service partially attained and of low risk.
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There were documented processes for the management of waste and hazardous substances in place and incidents are reported in a timely manner. Chemicals were stored safely throughout the facility. The building has a current code of compliance certificate. Resident rooms are spacious and personalised. There are bedrooms with ensuites and some rooms without ensuites closely

located to communal toilet/showers. There is sufficient space to allow the movement of residents around the facility using mobility aids or in lazy-boy chairs. The hallways and communal areas are spacious and accessible. The outdoor areas are safe and easily accessible and provide seating and shade. The service has implemented policies and procedures for civil defence and other emergencies. Six monthly fire drills are conducted. Housekeeping/laundry staff maintain a clean and tidy environment. All laundry and linen is completed on-site. There is plenty of natural light in all rooms and the environment comfortable with adequate ventilation and heating.

Partial Provisional:

The new wings are still under construction. A code of compliance has not yet been issued. There are ensuites in all rooms in the new wing and serviced apartments. There is adequate space to safely manoeuvre mobility aids and transferring equipment such as hoists.

## Restraint minimisation and safe practice

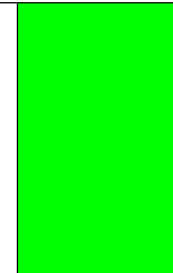
Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Some standards applicable to this service partially attained and of low risk.
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Restraint minimisation and safe practice policies 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. The service currently has two residents assessed as requiring the use of restraint (bed rails) and one resident requiring enablers (bedrails only). 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.

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control (IC) programme is implemented. The IC programme meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

## 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)
<b>Standards</b>	0	43	0	5	2	0	0
<b>Criteria</b>	0	92	0	7	2	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. Discussions with staff (eight caregivers, one enrolled nurse, three registered nurses (RN), one diversional therapist, one chef, one cleaner, one relieving clinical manager, one village manager) confirm their familiarity with the Code. Interviews with eight residents (three rest home and five hospital) and two families (hospital) confirm the services being provided are in line with the Code. The Code is discussed at resident, staff and quality meetings.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Informed consent processes were discussed with residents and families on admission. Written general and specific consents were evident in the six resident files (three hospital and three rest home level of care including one rest home resident in serviced apartment) reviewed. Care staff interviewed confirm consent is obtained when delivering cares. Resuscitation orders had been appropriately signed by the resident and general practitioner. The service acknowledges the resident is for resuscitation in the absence of a signed directive by the resident. The general practitioner (GP) had discussed resuscitation with families/EPOA where the resident was deemed incompetent to make a decision.</p> <p>Discussion with family members identifies that the service actively involves them in decisions that affect their relative's lives. Six admission agreements sighted were all signed.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>A policy describes access to advocacy services. Staff receive training on advocacy. Information about accessing advocacy services information is available in the entrance foyer. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Advocate support is available if requested. Interview with staff and residents informed they are aware of advocacy and how to access an advocate.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are encouraged to be involved in community activities and maintain family and friend's networks. On interview, all staff stated that residents are encouraged to build and maintain relationships. All residents interviewed confirmed that relative/family visiting could occur at any time.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a complaints policy that describes the management of the complaints process. Information about complaints is provided on admission to residents and their families/whānau. Feedback forms are available for residents/whānau in various places around the facility. Interviews with residents demonstrated an understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints.</p> <p>There is a complaints register. Verbal and written complaints are documented. There have been 13 complaints since the service opened in October 2015. One complaint was referred to the DHB. This complaint was investigated by the DHB and has now been closed. The corrective actions that arose from this complaint have been or are being implemented.</p> <p>All 13 complaints reviewed had noted an investigation, timeframes were met and where required, corrective actions were documented and implemented. Results and outcomes of the investigation are fed back to complainants. The complaints received are reported monthly to staff via the various site meetings. Discussions with residents confirmed that any issues are addressed and they feel comfortable to bring up any concerns.</p>
<p>Standard 1.1.2: Consumer Rights During Service</p>	FA	<p>There are posters of the Code on display throughout the facility and leaflets are available in the foyers. The service is able to provide information in different languages and/or in large print if requested. Information is</p>

<p>Delivery</p> <p>Consumers are informed of their rights.</p>		<p>also given to next of kin or enduring power of attorney (EPOA) to read with the resident and discuss. On entry to the service, the village manager discusses the information pack with the resident and the family/whānau. The information pack includes a copy of the Code.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The service has policies which align with the requirements of the Privacy Act and Health Information Privacy Code. Staff were observed respecting resident's privacy and could describe how they manage maintaining privacy and respect of personal property. Resident files include cultural and spiritual values. All residents interviewed stated their needs were met.</p> <p>There is a policy that describes spiritual care. Church services are conducted weekly. All residents interviewed indicated that resident's spiritual needs are being met when required. Staff education and training on abuse and neglect last occurred in February 2016.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>Summerset at Karaka has a Māori health plan that includes a description of how they achieve the requirements set out in the contract. The Māori health care plan was developed in consultation with representatives from Papakura Marae. There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with disability and other community representative groups as requested by the resident/family. Cultural needs are addressed in the care plan. Staff interviewed were able to describe how they can ensure they meet the cultural needs of residents identifying as Māori.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The service has established cultural policies aimed at helping meet the cultural needs of its residents. All residents interviewed reported that they were satisfied that their cultural and individual values were being met.</p> <p>Information gathered during assessment including resident's cultural beliefs and values, is used to develop a care plan, which the resident (if appropriate) and/or their family/whānau are asked to consult on. Staff received training on cultural awareness in February 2016.</p>
<p>Standard 1.1.7:</p>	FA	<p>Staff job descriptions include responsibilities of the position, ethics, advocacy and legal issues and staff sign a copy on employment. The abuse and neglect processes covers harassment and exploitation. Interviews</p>

<p>Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>		<p>with the village manager, relieving nurse manager, registered nurses and caregivers confirmed an awareness of professional boundaries. The RNs supervise staff to ensure professional practice is maintained in the service. Registered nurse and caregivers interviewed discussed professional boundaries, ethics and advocacy services. Management provide guidelines and mentoring for specific situations. All residents interviewed reported that the staff respected them.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>Summerset at Karaka uses the policies developed by the Summerset group to guide practice. The policies in use align with the Health and Disability Services Standards, for residents with aged care needs. There is a quality improvement programme that includes performance monitoring against clinical indicators and benchmarking against like services within the group. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training.</p> <p>There are implemented competencies for caregivers and registered nurses including but not limited to: insulin administration, medication, wound care and manual handling. RNs have access to external training.</p> <p>The first resident satisfaction survey since the service opened is scheduled for October. Feedback from residents is obtained via the weekly resident meetings and the quarterly family and friends meetings. Residents interviewed spoke very positively about the care and support provided. Staff interviewed had a sound understanding of principles of aged care and stated that they feel supported by the management team.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Residents interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. The service has policies and procedures available for access to interpreter services for residents (and their family/whānau). Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Incidents/accident forms reviewed (eleven) include a section to record family notification. All forms evidenced family were informed or if family did not wish to be informed. Relatives interviewed confirmed that they are notified of any changes in their family member's health status.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and</p>	FA	<p>Summerset at Karaka provides care for up to 41 residents across two service levels (hospital [medical and geriatric] and rest home care (excluding dementia care). The care centre is a two level facility. The ground floor includes the service areas and 10 serviced care apartments certified to provide rest home level care. There are thirty-one (rest home and hospital level) rooms on the first floor (all dual purpose), across two</p>

<p>appropriate to the needs of consumers.</p>		<p>wings.</p> <p>On the day of the audit, there were 33 residents. There were 29 residents in the 31 dual purpose beds (15 residents at rest home level care and 14 residents at hospital level care). There were four residents at rest home level of care in the ten serviced apartments. All residents were under the ARRC contract. There were no respite residents.</p> <p>The Summerset Group Limited Board of Directors have overall financial and governance responsibility and there is a company strategic business plan in place. Summerset at Karaka has a site specific business plan with measurable goals, which are reviewed regularly throughout the year. The annual review of the site specific business plan will take place after the service has been operating for 12 months.</p> <p>The village manager (non-clinical) has been in the role since the village opened in 2014. The village manager has a background in home and community management. The village manager is currently supported by the Summerset relieving clinical manager. The vacant nurse manager position has now been filled and the permanent clinical manager is due to start in September 2016. This person has a background in aged care clinical nursing leadership and management.</p> <p>The village manager reports to and receives support from the regional operations manager and another head office staff, as required. The village manager has attended at least eight hours of leadership professional development relevant to the role.</p> <p>Partial Provisional</p> <p>A partial provisional was also completed as part of this audit to assess a newly built 19 bed wing on the first level of the care facility. The wing has been assessed as suitable to provide dual-purpose beds (rest home and hospital levels of care). Furthermore, 10 serviced apartments opened on the ground level were verified as suitable to provide rest home level of care. With the increase in beds, the service will be able to provide rest home/hospital level care for up to 50 residents in the care centre and 20 rest home residents in serviced apartments.</p> <p>The village manager interviewed reported sign-off and handover of the new build to operations and is scheduled for 1 September 2016.</p> <p>A transition plan outlines the actions that are required to be completed prior to the scheduled opening. This plan is regularly updated.</p> <p>The village manager reported that the first week of September will be allocated towards introducing the two new wings to stakeholders and potential residents and their families. Two rest home level residents are on the waiting list and will be admitted into the care facility the second week of September. By the middle of September, new residents (rest home and hospital level) will gradually be admitted; staggering admissions to ensure that staffing is adequate to care for residents' needs</p>
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<p><b>Standard 1.2.2: Service Management</b></p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>During a temporary absence of the village manager, the Summerset roving village manager will cover the village manager's role. During an absence of the clinical manager, the Summerset roving relieving clinical manager will cover the role. The regional operations manager and the head office clinical quality management team provide regular oversight and support.</p> <p>An interim clinical manager/RN is in place until a permanent replacement begins employment on 12 September.</p> <p>Partial Provisional</p> <p>The increased number of beds has resulted in a clinical nurse leader/RN vacancy. This individual will assist the clinical manager. The recruitment process for this position is underway and is scheduled to be completed in August 2016. The village manager reported that the position will be filled internally and will result in a staff RN vacancy that will need to be filled.</p> <p>The clinical manager will be supported by the clinical nurse leader in their absence. For extended absences, Summerset has a national team of qualified nurse leaders.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>Summerset at Karaka is implementing the Summerset organisation's quality and risk management system. The content of the policies and procedures is detailed to allow effective implementation by staff. The service's policies are reviewed at an organisational level.</p> <p>The quality and risk management system is designed to monitor contractual and standards compliance. The Summerset group has a 'clinical audit, training and compliance' calendar. The calendar schedules the training and audit requirements for the month and the village manager completes a 'best practice' sheet confirming completion of these requirements. The best practice sheet reports (but not limited to): meetings held, induction/orientation, audits, competencies and projects. This is forwarded to head office as part of the ongoing monitoring programme.</p> <p>The service is implementing the organisations internal audit programme. Monthly analysis of audit results is completed and provided to staff via site meetings and staff notice boards. Issues arising from internal audits are developed into corrective action plans. The corrective action plans are discussed at staff meetings and once implemented are reviewed and signed off by the village manager or clinical nurse manager.</p> <p>There are monthly accident/incident benchmarking reports completed by the nurse manager that break down the data collected across the rest home, hospital and staff incidents/accidents. Infection control is also included as part of benchmarking across the organisation. A project has been commenced to reduce the incidence of falls with initial results showing an improvement in outcomes for residents.</p>



		<p>Summersets clinical and quality manager analyses data collected via the monthly reports and corrective actions are required based on benchmarking outcomes. Summerset has a data tool "Sway- the Summerset Way". Sway is integrated and accommodates the data entered. There is a health and safety and risk management programme in place including policies to guide practice. The property manager is the health and safety representative (interviewed). Health and safety internal audits are completed.</p> <p>There is a meeting schedule including monthly quality improvement (full facility) meetings that includes discussion about clinical indicators (e.g. incident trends, infection rates and health and safety). Registered nurse meetings are held monthly.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>There is an accidents and incidents reporting policy. The village manager investigates accidents and near misses and analysis of incident trends occurs. Data is linked to the organisation's benchmarking programme and used for comparative purposes. There is a discussion of incidents/accidents at monthly quality meetings including actions to minimise recurrence. A registered nurse conducts timely clinical follow up of residents. Eleven incident forms sampled (from a sample of resident files) demonstrated that appropriate clinical observations did not always occur following incidents (link 1.3.6.1). Discussions with the village manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. The village manager advised there have been no adverse events since the last audit that would have triggered a section 31 notification.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	PA Low	<p>There are human resources policies to support recruitment practices. A list of practising certificates is maintained. Six staff files were selected for audit (one relieving clinical manager, one registered nurse, one caregiver, one property manager, one activities coordinator and one housekeeper). Two of six files requested could not be located on day of audit (acting clinical manager and property officer). Four of six files reviewed had all relevant documentation relating to employment completed and performance appraisals completed after the first three months of employment. Annual performance reviews are due to commence in October 2016.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme includes documented competencies and induction checklists (sighted in files). Staff interviewed were able to describe the orientation process and believed new staff were adequately orientated to the service. There is an annual education plan that is outlined on the 'clinical audit, training and compliance calendar'. The plan is being implemented. A competency programme is in place with different requirements according to work type (e.g. caregivers, registered nurse and kitchen). Core competencies are completed and a record of completion is maintained on staff files as well as being scanned into 'Sway'. The service has previously experienced difficulty in accessing interRAI training to</p>

		<p>meets its contractual requirements. The service now has three RNs trained in interRAI.</p> <p>Staff interviewed were aware of the requirement to complete competency training.</p> <p>Partial Provisional</p> <p>The general orientation programme is for a maximum period of three months although the interim clinical manager reported that they make every effort to complete new staff orientation within three weeks. The staff education and training programme is linked to the education calendar. A Careerforce education officer is appointed and Careerforce training is scheduled to begin for the care facility during the 4th quarter.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>PA Low</p>	<p>The village manager and relieving clinical nurse manager work 40 hours per week (Monday to Friday) and are available on call for any emergency issues or clinical support. The service provides 24-hour RN. There are six care assistants on morning shifts, five on the afternoon shifts and four on night shifts. A staff availability list ensures that staff sickness and vacant shifts are covered. Caregivers interviewed confirmed that staff are replaced. Staffing levels and skills mix policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery.</p> <p>Summerset policy includes staff rationale and skill mix. The staff interviewed report there are sufficient staff rostered on to manage the care requirements of the residents at all care levels in the dual purpose beds. In addition to the relieving clinical manager (a registered nurse) who works full-time, there is one registered nurse on at any one time. The registered nurse on each shift is aware that extra staff can be called on for increased resident requirements.</p> <p>The service has an enrolled nurse who leads the dedicated serviced apartment care team (under the direction and supervision of the registered nurse). The serviced apartment care team (interviewed) report there are sufficient staff rostered to meet the care needs of the rest home residents in the serviced apartments. There is at least one staff member rostered onto the serviced apartments 24 hours per day to meet the care requirements of the rest home residents.</p> <p>Interviews with staff, residents and family members identify that staffing is adequate to meet the needs of residents.</p> <p>Partial Provisional:</p> <p>A transitional safe staffing matrix has been developed to ensure staff numbers are adequate to meet the needs of the additional numbers of residents. Staffing levels correspond to resident numbers and acuity of the residents (e.g. rest home and hospital levels of care). The village manager reported that resident admissions will be staggered to ensure safe staffing levels.</p> <p>Currently, one caregiver is rostered 24/7 for the ten serviced apartments where four rest home level</p>

		<p>residents reside. The village manager reported that the addition of 10 serviced apartments will not change staffing levels.</p> <p>Two senior caregivers and a part-time RN are scheduled to begin work in August. The village manager reported that these new staff will have completed their orientation to the care facility before new residents are accepted.</p> <p>A nurses' station (hot desk) is planned for the new wing of the care facility. Currently this space, just outside of the doors leading to the wing, is being used to store equipment.</p> <p>A nurses' station is located in close proximity to the new serviced apartments.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are protected from unauthorised access by being locked away in the nurses' stations. Informed consent to display photographs is obtained from residents/family/whānau on admission. Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. Entries in records are legible, dated and signed by the relevant caregivers or registered nurse.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>All residents have a needs assessment completed prior to entry that identifies the level of care required. The nurse manager screens all potential enquiries to ensure the service can meet the required level of care and specific needs of the resident.</p> <p>Residents (three rest home and five hospital) and relatives (two hospital) interviewed stated that they received sufficient information on admission and discussion was held regarding the admission agreement. The admission agreement reviewed aligns with a) -k) of the ARCC.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>There is an exit, discharge and transfer policy that describes guidelines for death, discharge, transfer, documentation and follow up. All relevant information is documented and communicated to the receiving health provider or service. Follow up occurs to check that the resident is settled or, in the case of death, communication with the family is made.</p>

<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>There are medicine management policies and procedures that align with recognised standards and guidelines for safe medicine management practice in accordance with the Medicines Care Guide for Residential Aged Care 2011. RNs are responsible for the administration of medications in the rest home/hospital care centre. Senior care assistant's complete competencies for the checking and witnessing of medications as required. Registered nurse medication competencies and education has been completed annually. It was noted that the controlled drug register did not always have checks documented weekly. The service had identified this issue through their internal audit process and an action plan was put in place. The service rectified this issue with the last two weeks of weekly CD checks documented. They are planning to continue to monitor this weekly. The medication fridge is monitored daily. All eye drops and ointments in use had been dated on opening. All medications were evidenced to be checked on delivery with any discrepancies fed back to the supplying pharmacy. The service uses an electronic medication system. Standing orders are not used. There were no residents self-medicating on the day of audit.</p> <p>Twelve resident medication charts on the electronic medication system were reviewed (six rest home and six hospital). The charts had photograph identification and allergy status recorded. Staff recorded the time, date and effectiveness of 'as required' medications. The nurse manager monitors missed medications.</p> <p>All 12 medication charts reviewed identified that the GP had reviewed the medication chart three monthly.</p> <p>Partial provisional:</p> <p>There is one existing medication room for the care facility. This treatment room will service the new wing upstairs and all of the serviced apartments downstairs. Medications for rest home residents in serviced apartments are transported downstairs in the medication trolley for medication administration.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>An external contractor is responsible for the provision of meals on-site. There is an eight week rotating menu approved by the dietitian. The menu includes resident preferences. The chef manager (interviewed) is notified of any changes to resident's dietary requirements. Resident likes/dislikes and preferences are known and accommodated with alternative meal options. Meals are delivered in a bain marie to the care centre and hot box to the serviced apartments. Special requests and alternative meals are plated and labelled. Texture modified meals, fortified foods, protein drinks and diabetic desserts are provided. The cook receives a dietary profile for each resident.</p> <p>The fridge, freezer and end cooked food temperatures are recorded twice daily. All foods are stored correctly and date labelled. Cleaning schedules are maintained. Chemicals are stored safely within the kitchen. Staff were observed wearing correct personal protective clothing when entering the kitchen. The chemical provider completes a functional test on the dishwasher monthly.</p> <p>Staff working in the kitchen have food handling certificates and chemical safety training.</p>

		<p>The chef manager receives feedback from resident meetings and surveys.</p> <p>Partial provisional:</p> <p>Additional plates, cups and cutlery have been purchased. Residents in the care facility are encouraged to eat their meals in the dining area. The dining area currently accommodates 40 residents with plans to add an additional table and six chairs. Space is available to add more tables and chairs if needed.</p> <p>There is a downstairs dining area for rest home level residents living in serviced apartments</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The reason for declining service entry to residents should this occur is communicated to the resident or family/ whanau and they are referred to the original referral agent for further information.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>The initial support plan is developed with information from the initial assessment. Clinical risk assessments reviewed were completed on admission where applicable and reviewed six monthly as part of the interRAI assessment. Outcomes of risk assessment tools have been used to identify the needs, supports and interventions required to meet resident goals.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	PA Moderate	<p>Four of six resident's care plans reviewed described all the individual support and interventions required to meet the resident goals. The care plans reviewed overall reflected the outcomes of risk assessment tools. Care plans demonstrate service integration and include input from allied health practitioners.</p> <p>Short-term care plans are used for changes in health status. A shortfall was identified around interventions for short term needs. Short-term care plans reviewed were evaluated and either resolved or if an ongoing problem added to the long-term care plan. There is documented evidence of resident/family/involvement in the care planning process. Residents/relatives interviewed confirmed they participate in the care planning process.</p>

<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Moderate</p>	<p>When a resident's condition changes, the RN initiates a review and if required a GP or nurse specialist consultation. Relatives interviewed state their relative's needs are met and they are kept informed of any health changes. There was documented evidence in the resident files of family notification of any changes to health including infections, accidents/incidents and medication changes. Residents interviewed state their needs are being met. Short-term care plans are used for short term needs (link 1.3.5.2).</p> <p>Adequate dressing supplies were sighted. Initial wound assessments with ongoing wound evaluations and treatment plans were in place for five wounds (three skin tears and two chronic wounds). There were no pressure injuries. Wounds are re-assessed at least monthly. Evaluation comments were documented at each dressing change to monitor the healing progress. The RN and relieving nurse manager confirmed there was a wound nurse specialist available as required. There is evidence of wound nurse involvement in the chronic wound.</p> <p>Contenance products are available and resident files include a urinary continence assessment, bowel management and continence products identified for day use, night use and other management. Specialist continence advice is available as needed.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The service employs a full-time diversional therapist (DT) and part time recreational assistant who deliver a seven day programme from 10.30 to 3.30pm daily. The activity team attend Summerset training sessions and the regional DT group.</p> <p>The integrated rest home and hospital programme is flexible and adapted to meet the resident's level of abilities. The programme is planned a month in advance and includes set activities with the flexibility to add other activities of interest or suggestions made by residents. Activities meet the recreational needs of both resident groups ensuring all residents have the opportunity for outings, shopping, and attending community groups/events including village activities. One on one activities occur for those residents unable to participate or choose not to join group activities.</p> <p>Community visitors include monthly entertainers and church services. Families are encouraged to bring in their pets when visiting. Weekly social afternoons are held.</p> <p>Residents are encouraged to maintain their former community links. The service has a mobility van for outings for rest home and hospital residents.</p> <p>Residents have the opportunity to feedback on the programme through resident meetings and surveys. Resident files reviewed contained resident activity assessments and plans that were reviewed at least six monthly.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>There is evidence of resident and family involvement in the review of resident centred care plans. All initial care plans were evaluated by the registered nurses within three weeks of admission. Written evaluations were completed six monthly or earlier for resident health changes in all files reviewed. There is evidence of multidisciplinary (MDT) team involvement in the reviews including input from the GP and any allied health professionals involved in the resident's care. Families are invited to attend the MDT review and asked for input if they are unable to attend. Short-term care plans sighted have been evaluated by the RN. The GP completes three monthly reviews.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The service provided examples of where a resident's condition had changed and the resident was reassessed for a higher level of care.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>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. Personal protective clothing was available for staff and seen to be worn by staff when carrying out their duties on the day of audit. Chemicals were stored safely throughout the facility. The chemical supplier provides chemical safety training and completes monthly audits on the effectiveness of chemicals.</p> <p>Partial Provisional:</p> <p>The designated cleaners' cupboards are located in the existing spaces of the care facility and serviced apartments and are kept locked. There are adequate stores of protective clothing and equipment associated with waste or hazardous substances being handled. The sluice room, located in the existing care facility, is within adequate proximity to the new care facility wing.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with</p>	<p>PA Low</p>	<p>The building has a code of compliance certificate in place. A building warrant of fitness will be issued in October 2016 after one year in operation. A 19 bed wing is under construction and safely cordoned off. There is a full-time property manager who oversees the property, property assistant duties and gardener.</p>

<p>an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>The property manager is responsible for the care centre and village and available on call for facility matters. Planned and reactive maintenance systems are in place and maintenance requests are generated through the Sway (Somerset way) online system (property services requests). All equipment was purchased new and due for electrical testing and calibrations in October 2016. Hot water temperatures are tested monthly and recorded with readings between 42-45 degrees Celsius. Corrective actions have been recorded for temperatures outside of the acceptable range. Preferred contractors for essential services are available 24/7.</p> <p>The care centre is located on the first floor. Serviced apartments are on the ground floor. 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 an outdoor balcony on the first floor with seating and shade. There are plans to create a memorial garden, raised gardens and potted plants on the balcony for resident enjoyment. The internal and external areas of the facility are well maintained.</p> <p>The caregivers and registered nurses (interviewed) state they have all the equipment required to safely provide the care documented in the care plans.</p> <p>Partial Provisional:</p> <p>The new wings are still under construction. A code of compliance has not yet been issued.</p> <p>Planned and reactive maintenance systems are in place and maintenance requests are generated through the online system using the Sway programme. There is a lift between the ground floor and the first floor.</p> <p>Equipment has been purchased for the new wings and is scheduled to arrive on the 18th August. Space for the storage of existing medical equipment will be moved to accommodate a nurse's station for the new care facility wing (link to finding 1.2.8.1).</p> <p>Corridors are wide enough in all areas to allow residents to pass each other safely with safe access to communal areas and outdoor areas. Handrails next to toilets in the new wings of the care facility and serviced apartments have not been yet installed.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to</p>	<p>FA</p>	<p>All rooms have ensembles except for the eight standard rooms which have shared toilet and showers closely located to their rooms. Visual inspection evidences 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 communal toilets closely located to the dining and lounge areas. Communal toilet/shower facilities have a system that indicates if it is engaged or vacant.</p> <p>Partial provisional:</p> <p>There are ensembles in all rooms in the new wing and serviced apartments. There are communal toilets near</p>



<p>personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>		<p>the lounge areas. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. Communal toilet facilities have a system that indicates if it is engaged or vacant</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>All rooms are single. There is adequate room to safely manoeuvre mobility aids and transferring equipment such as hoists in the resident bedrooms. 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.</p> <p>Partial provisional:</p> <p>All residents' rooms are spacious with full ensuites. There is adequate space to safely manoeuvre mobility aids and transferring equipment such as hoists. The doors are wide enough for ambulance access and the lift is large enough for ambulance trolleys. Residents and families are encouraged to personalise their rooms as viewed.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>Communal areas within the facility include a large main lounge that can accommodate rest home and hospital level residents and where most activities take place. There is a family room and additional smaller lounge where quiet activities can take place. There are seating alcoves within the facility. The communal areas are easily accessible for residents.</p> <p>Partial provisional:</p> <p>Residents in the new wing in the care facility will access the current open plan lounge and dining area. A lounge and dining area is also available on the ground level to accommodate the serviced apartments.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. All linen and personal clothing is laundered on-site. The serviced apartment caregivers on all shifts complete laundry duties seven days a week. A laundry chute is used to deliver dirty laundry from the care centre to the downstairs laundry. The laundry is well equipped. There is an upstairs sluice room and one in the laundry with personal protective equipment available. The laundry has defined clean/dirty areas and an entry and exit door with adequate ventilation.</p> <p>Cleaning trolleys sighted were well equipped and are kept in designated locked cupboards when not in use. There are locked chemical boxes fixed to the cleaning trolleys. External (chemical provider) monitors the effectiveness of laundry and cleaning processes.</p> <p>Partial provisional:</p>

		<p>The caregivers for the serviced apartments are also responsible for laundry services. The village manager reported that as the care facility grows, dedicated laundry staff will be employed.</p> <p>There are currently two dedicated housekeeping staff available seven days a week (5.5 hours per day). The staffing matrix plan reflects an increase in the number of housekeeping staffing hours as resident numbers increase.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	PA Low	<p>There are emergency and civil defence plans to guide staff in managing emergencies and disasters. Emergencies, first aid and CPR are included in the mandatory in-service programme. There is a first aid trained staff member on every shift. Summerset at Karaka has an approved fire evacuation plan and fire drills occur six monthly. Smoke alarms, sprinkler system and exit signs are in place. The service has alternative cooking facilities (three BBQ's) available in the event of a power failure. There are civil defence kits in the facility and stored water. Call bells were evident in residents' rooms, lounge areas and toilets/bathrooms. The facility is secured at night.</p> <p>Partial provisional:</p> <p>An application for an approved updated evacuation plan has been submitted. A fire evacuation drill is scheduled for the first week of September. The facility is well prepared for civil emergencies and has emergency lighting, a store of emergency water and a gas BBQ for alternative heating and cooking.</p> <p>A call bell system is available with indicator panels in each wing. There are four call bell points in the serviced apartments (dining area, bedroom, shower and toilet) and three call bell points in each resident room in the care facility (bedroom, toilet, shower). The call bell system has not had final signoff.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>Visual inspection evidences that the residents have adequate natural light in the bedrooms and communal rooms, safe ventilation and an environment that is maintained at a safe and comfortable temperature. There is ceiling heating throughout the facility. Resident's rooms have individual heating with thermostat controls in the room.</p> <p>Partial provisional:</p> <p>All residents' rooms in the care facility have large external windows with ample natural light. The residents' rooms in the serviced apartments on the ground level have ranch sliders leading outdoors. Heating is thermostatically controlled in each resident room with panels installed in the ceilings. There are also heat pumps and air conditioning installed in hallways and communal areas.</p>

<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>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 officer (registered nurse) has a signed job description. The infection control programme is linked into the quality management system and reviewed annually at head office in consultation with infection control officers. The facility meetings include a discussion of infection control matters. Spot audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation.</p> <p>Visitors are asked not to visit if they are unwell. Influenza vaccines are offered to residents and staff. Hand sanitisers are available throughout the facility.</p> <p>Partial provisional:</p> <p>The responsibility for infection prevention control is clearly defined and there are lines of accountability for infection prevention control matters in the organisation leading to the leadership team, executive team and the board. There are no changes with the increase in residents.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The infection control officer is new into the role and has completed the online Ministry of Health infection control training. The infection control officer also attends the DHB infection control meetings and Summerset infection control updates.</p> <p>There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The infection control officer and the infection control team (comprising housekeeping, laundry, diversional therapy and care staff) have good external support from the Summerset group, the infection control nurse specialist at the DHB and the medical officer. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and</p>	<p>FA</p>	<p>There are comprehensive infection control policies that are current and reflected the Infection Control Standard SNZ HB 8134:2008, legislation and good practice. These are across the Summerset organisation and were reviewed last in September 2014. The infection control policies link to other documentation and cross reference where appropriate.</p>

are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.		
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control officer is responsible for coordinating and providing infection control education and training to staff. The induction package includes specific training around handwashing competencies and standard precautions. On-going training occurs annually as part of the training calendar set at head office.</p> <p>Information is provided to residents and visitors that is appropriate to their needs and this is documented in the resident's notes.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>The infection control policy includes a surveillance policy that includes 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 SWAY electronic system. The infection control officer provides infection control data, trends and relevant information to the infection control committee and clinical/quality meetings. Areas for improvement are identified, corrective actions developed and followed up. The facility is benchmarked against other Summerset facilities of similar size and benchmarking results are fed back to the infection control officer and used to identify areas for improvement. Infection control audits are completed and corrective actions are signed off (sighted). Surveillance results are used to identify infection control activities and education needs within the facility.</p> <p>There have been no outbreaks since the facility opened in October 2015.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service has documented systems in place to ensure the use of restraint is actively minimised. There were two residents using a restraint and one resident with an enabler on the day of audit. All restraints and enablers are bed rails. Two restraint files and one enabler file were sampled. The enabler file sampled evidenced that the resident had requested the use of the enabler and that the enabler use is voluntary.</p> <p>Staff interviews and staff records evidence guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. Staff education on RMSP/enablers has been provided in March and May 2016. A registered nurse is the</p>

		designated restraint coordinator.
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>A registered nurse is the restraint coordinator (interviewed). The restraint coordinator has a signed job description which outlines the accountabilities and responsibilities of the role. Assessment and approval processes for restraint use include the restraint coordinator, registered nurses, resident/or representative and medical practitioner.</p> <p>All care staff are required to attend restraint minimisation training annually.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	PA Low	<p>Only registered nursing staff can assess the need for restraint. Restraint assessments are based on information in the resident's care plan, discussions with the resident and family and observations by staff. A restraint assessment tool meets the requirements of the standard. Two hospital level residents' files where restraint was being used were selected for review. Each file included a restraint assessment and consent form that was signed by the resident's family. Restraint use is linked to the resident's care plan and is regularly reviewed.</p> <p>The organisational policy requires a comprehensive assessment for residents who require restraint or enabler to be completed. Assessments were undertaken by suitably qualified and skilled staff, in partnership with the family/whānau, in the restraint and enabler files sampled. Assessments and consents for the use of a restraint or enabler were not fully completed and not all consents were signed correctly. The restraint coordinator, the resident and/or their representative and a medical practitioner were involved in the assessment and consent process.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The restraint minimisation and safe practice policy identifies that restraint is only put in place where it is clinically indicated and justified and approval processes are obtained/ met. There is an assessment form/process that is required to be completed for all restraints and enablers (Link 2.2.2.1). A restraint register is in place. The register identifies the residents that are using a restraint and the type(s) of restraint used. The restraint assessment and on-going evaluation of restraint use process includes reviewing the frequency of monitoring residents while on restraint. The registered nurse is responsible for documenting a</p>

		restraint/enabler care plan which details interventions to manage the risks associated with the use of the restraint or enabler. Not all residents using a restraint or an enabler had a care plan or interventions documented in their care plan to manage the risks associated with the use of bed rails (link 1.3.5.2).
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	Restraint use is reviewed three monthly by the restraint committee during restraint meetings. The review process includes discussing whether continued use of restraint is indicated.  The service has documented evaluation of restraint use for individuals using restraint. In the files reviewed, evaluations had been completed with the resident and/or family/whānau and the restraint coordinator. The evaluation is documented in the resident's progress notes. Evaluation timeframes are determined by policy and risk levels.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The restraint programme, including reviewing policies and procedures and staff education is evaluated annually by the national quality manager and the national education manager.

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.7.3</p> <p>The appointment of appropriate service providers to safely meet the needs of consumers.</p>	PA Low	<p>Summerset has detailed policies and process to guide the recruitment, orientation and ongoing management of staff. Summerset at Karaka has a site specific orientation check list that is completed for all new staff. The village manager maintains a copy of all relevant staff information securely in the village manager's office and in an online system. Not all staff information was accessible on the day of audit.</p>	<p>Two of six staff files selected for audit (the relieving clinical manager and property manager who transferred from another Summerset site to Karaka in March), could not be located on the day of audit. Documented evidence of the recruitment, orientation training, performance management and site specific orientation processes for these staff could not be located either on-site or at head office.</p>	<p>Ensure a copy of the relevant staff information (recruitment, qualifications, orientation training, performance management) is available on-site for all staff.</p>

				90 days
<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	PA Low	<p>Partial Provisional</p> <p>Two senior caregivers and a part-time RN are scheduled to begin work in August. The village manager reported that these new staff will have completed their orientation to the care facility before new residents are accepted.</p> <p>A nurses' station (hot desk) is planned for the new wing of the care facility. Currently this space, just outside of the doors leading to the wing, is being used to store equipment</p>	<p>Partial Provisional:</p> <p>The main nursing station is a significant distance away (approximately 44 meters) from the new wing. A nurses' station (hot desk) is planned to be installed just outside of the doors leading to the new care facility wing.</p>	<p>Ensure a nurses' station is placed in close proximity to the new wing in the care facility.</p> <p>Prior to occupancy days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	PA Moderate	<p>Four of six resident's care plans reviewed met all their assessed residents needs and supports. Three further hospital files were reviewed around restraint/enabler use. These identified gaps around restraint interventions.</p>	<p>(i) Two rest home resident care plans did not document interventions for diabetic management (one insulin dependent and one on oral medication). (ii) One rest home resident care plan did not describe interventions for wandering as recorded on the accident/incident form. (iii) There were no documented interventions for one rest home resident with weight loss (link tracer) and no weekly weighs for one hospital resident as per care plan. (iv) Interventions to manage the risks associated with the use of the restraint or enabler were not fully documented in the care plan for one hospital resident using an enabler and one hospital resident using a restraint. (v) One</p>	<p>Ensure care plans reflect the resident current needs and supports.</p> <p>60 days</p>



			hospital resident (recently admitted) using a restraint had no restraint care plan documented.	
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Moderate</p>	<p>There are a number of monitoring forms available for use including (but not limited to): pain monitoring, restraint, blood sugar levels, weight, neurological observation, behaviour monitoring, wound evaluations, food and fluid intake and repositioning charts. RNs review the forms/charts and completed risk assessments for any changes to health status. Neurological observations hadn't been fully completed or implemented for unwitnessed falls. There was no evidence of dietitian input for the two rest home residents with weight loss.</p>	<p>(i) Neurological observations had not been implemented for three residents with unwitnessed falls including one with laceration to the eye, (ii) two sets of neurological observation commenced had not been completed as per protocol. (iii) There was no evidence of dietitian input for the two rest home residents with weight loss</p>	<p>(I) and (ii) Ensure neurological observations are completed for all unwitnessed falls and known head injury. (iii) Ensure dietitian input is considered for residents with weight loss.</p> <p>60 days</p>
<p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p>	<p>PA Low</p>	<p>Partial Provisional: Planned and reactive maintenance systems are in place and maintenance requests are generated through the online system using the Sway programme. There is a lift between the ground floor and the first floor. The new wings are still under</p>	<p>Partial Provisional: A code of compliance has not yet been issued. Rails adjacent to the toilets have not yet been installed.</p>	<p>Ensure a building code of compliance is issued and handrails are installed next to each toilet before admitting residents to</p>

		construction. A code of compliance has not yet been issued. Handrails next to toilets in the new wings of the care facility and serviced apartments have not been yet installed.		these areas.  Prior to occupancy days
Criterion 1.4.7.1  Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.	PA Low	Partial provisional:  Summerset at Karaka has an approved fire evacuation plan for the current facility and fire drills have occurred six monthly. A fire drill is scheduled for the opening of the new wings.	Partial Provisional : A fire evacuation drill is scheduled for the first week of September	Ensure a fire drill is completed prior to occupancy  Prior to occupancy days
Criterion 1.4.7.3  Where required by legislation there is an approved evacuation plan.	PA Low	Partial provisional:  An application for an approved updated evacuation plan has been submitted. A fire evacuation drill is scheduled for the first week of September. The facility is well prepared for civil emergencies and has emergency lighting, a store of emergency water and a gas BBQ for alternative heating and cooking	Partial Provisional: An approved updated evacuation plan has not been received. The call bell system requires final testing and sign-off before it can be deemed fully operational	Ensure the updated fire evacuation plan is approved  Prior to occupancy days
Criterion 1.4.7.5  An appropriate 'call system' is available to	PA Low	Partial Provisional:  A call bell system is available	Partial Provisional: The call bell system requires final testing and sign-off before	Partial Provisional: Ensure the

<p>summon assistance when required.</p>		<p>with indicator panels in each wing. There are four call bell points in the serviced apartments (dining area, bedroom, shower and toilet) and three call bell points in each resident room in the care facility (bedroom, toilet, shower). The call bell system has not had final signoff</p>	<p>it can be deemed fully operational</p>	<p>call bell system is signed off as fully operational before accepting residents in the new wings</p> <p>Prior to occupancy days</p>
<p>Criterion 2.2.2.1</p> <p>In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:</p> <p>(a) Any risks related to the use of restraint;</p> <p>(b) Any underlying causes for the relevant behaviour or condition if known;</p> <p>(c) Existing advance directives the consumer may have made;</p> <p>(d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;</p> <p>(e) Any history of trauma or abuse, which may have involved the consumer being held against their will;</p> <p>(f) Maintaining culturally safe practice;</p> <p>(g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);</p>	<p>PA Low</p>	<p>The restraint coordinator reviews the assessments completed by the registered nurses and discusses the outcome of the assessment with the resident and or family/whānau and medical practitioner before the decision to use a restraint (or enabler) is made. Not all sections of the comprehensive restraint/enabler assessment form had been completed in the files sampled (also link 1.3.5.2). Consent for the use of a restraint or enabler is to be obtained as part of the assessment process. The resident using an enabler had the consent for the enabler use signed by a family member.</p>	<p>i) The risks associated with the use of a restraint or an enabler were not fully documented as part of the assessment process for one hospital resident using a restraint and one hospital resident using an enabler.</p> <p>ii) One hospital resident (recently admitted) using a restraint had not had an assessment for the use of the restraint fully completed or the consent for use of a restraint signed.</p>	<p>i) Ensure that all sections of the restraint assessment form are completed and the risks associated with the use of the restraint or enabler are documented as part of the assessment process.</p> <p>ii) Ensure that the assessment and consent for the use of a restraint are</p>

(h) Possible alternative intervention/strategies.				<p>fully completed for all residents using a restraint.</p> <p>90 days</p>
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display
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End of the report.