

# Summerset Care Limited - Summerset in the Vines

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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:

<b>Legal entity:</b>	Summerset Care Limited
<b>Premises audited:</b>	Summerset in the Vines
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 18 February 2019      End date: 19 February 2019
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	41

# 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 in the Vines provides care to 43 residents at hospital and rest home level care. On the day of the audit there were 41 residents in total.

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.

The service is managed by a village manager who has been in the role for three years. The village manager is supported by a care centre manager who has been in the position since December 2017. The care centre manager is supported by the clinical nurse lead. Management are supported by a regional operations manager and regional quality manager. The residents and relatives interviewed spoke positively about the care and support provided.

There were four areas for improvement identified at this audit relating to care planning, hot water temperatures, first aid training and infection control meetings.

## 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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The facility provides care in a way that focuses on the individual resident. There is a Māori health plan and cultural safety policy supporting practice. Cultural assessment is undertaken on admission and during the review process. The service functions in a way that complies with the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and related services is readily available to residents and families. Policies are available that support residents' rights. Residents and where appropriate their family/whānau are being provided with appropriate information to assist them to make informed choices and give informed consent. Care plans accommodate the choices of residents and/or their family. Complaints processes are being implemented and complaints and concerns are managed and documented. Residents and family interviewed verified ongoing involvement with community.

## 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.
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Summerset in the Vines implements a quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to include monthly quality improvement meetings. Surveys and monthly resident meetings provide residents and families with an opportunity for feedback about the service. Quality performance is reported to staff at meetings and includes discussion about incidents, infections and internal audit results. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has an orientation

programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care. There is a staffing policy in place.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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The service uses an electronic patient management system. There is a well-developed information pack available for residents and families/whānau at entry. Assessments, long-term care plans and evaluations were completed by the registered nurses and risk assessment tools and monitoring forms were available and implemented. A recreational therapist plans and implements the activity programme. The activities meet the individual recreational needs and preferences of the consumer groups. There are outings into the community and visiting entertainers. There are medicine management policies in place that meets legislative requirements. Staff responsible for the administration of medications completes annual medication competencies and education. The general practitioner reviews the medication charts three monthly. The food service is contracted to an external contract company. Resident's individual dietary needs were identified and accommodated. Staff have attended food safety and hygiene training.

## 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 warrant of fitness. Resident bedrooms are spacious and personalised. There is a mix of bedrooms with ensembles, shared ensembles or access to communal toilet/showers. There was sufficient space to allow the movement of residents around the facility using mobility aids or lazy-boy chairs. The hallways and communal areas were spacious and accessible. The outdoor areas were safe and easily accessible and provide seating and shade. The service has implemented policies and procedures for civil defence and other emergencies and six-monthly fire drills are conducted. All laundry and linen services are completed on-site. There is plenty of natural light in all rooms and the environment is comfortable with adequate ventilation and heating.

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

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Some standards applicable to this service partially attained and of low risk.
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The infection control programme is appropriate for the size and complexity of the service. The infection prevention and control coordinator and the care centre manager are responsible for coordinating and providing education and training to staff. Ongoing training occurs annually as part of the training calendar. Care plans include infection prevention and control interventions as appropriate. The infection control manual outlined the scope of the programme and included a comprehensive range of policies and guidelines. Surveillance programme is implemented including audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Somerset 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)
<b>Standards</b>	0	46	0	4	0	0	0
<b>Criteria</b>	0	97	0	4	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)
<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
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Discussions with 11 care staff (six caregivers, four registered nurses (RN) including the clinical nurse lead and one activities coordinator) confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Four residents (two rest home and two hospital) and seven relatives (four rest home and three hospital) were interviewed and confirmed the services being provided are in line with the Code. Observation during the audit confirmed this in practice.
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 processes were discussed with residents and families on admission. Written general and specific consents were evident in the seven resident records (three rest home residents and four hospital level residents). Caregivers, RNs, clinical nurse lead and the care centre manager interviewed, confirmed consent is obtained when delivering cares. Resuscitation orders are appropriately signed by the resident and general practitioner (GP) and discussion with the family is documented. Advance care plans were signed for separately. Discussion with family members identified that the service actively involves them in decisions that affect their relative's lives. Seven long-term admission agreements were sighted and had been signed on admission.



<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>	<p>FA</p>	<p>Residents are provided with a copy of the Code on entry to the service. Residents interviewed confirmed they are aware of their right to access independent advocacy services and advocacy pamphlets are available at reception. Discussions with relatives confirmed the service provides opportunities for the family/enduring power of attorney (EPOA) to be involved in decisions. The resident files include information on residents' family/whānau and chosen social networks.</p>
<p>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>	<p>FA</p>	<p>Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. Activities programmes include opportunities to attend events outside of the facility including activities of daily living, for example, shopping and attending cafés and restaurants. Interview with staff, residents and relatives informed residents are supported and encouraged to remain involved in the community and external groups. Relatives and friends are encouraged to be involved with the service and care.</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>	<p>FA</p>	<p>The organisational complaints policy states that the village manager has overall responsibility for ensuring all complaints (verbal or written) are fully documented and investigated. A complaints procedure is provided to residents within the information pack at entry. Feedback forms are available for residents/relatives in various places around the facility. There is an electronic complaint register that includes relevant information regarding the complaint. The number of complaints received each month is reported monthly to staff via the various meetings. There have been nine complaints received (seven in 2018 and two in 2019 year to date) relating to the care centre since the last audit. Eight complaints reviewed included follow-up meetings and letters, resolutions were completed within the required timeframes and one is still ongoing.</p> <p>Two complaints made in April and May 2018 were made through the HDC, the service has completed investigations for both complaints with no further action required for one of the complaints, an HDC letter on 3 July 2018 confirming this and the other complaint is ongoing with the last update on 25 January 2019.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>The service provides information to residents that include the Code, complaints and advocacy. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Residents and relatives interviewed identified they are well informed about the Code of Rights. Monthly resident meetings provide the opportunity to raise concerns. An annual residents/relatives survey is completed. Staff receive training about the Code, which was last completed in August 2018</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>Staff interviewed could describe the procedures for maintaining confidentiality of resident records, resident's privacy and dignity. House rules and a code of conduct are signed by staff at commencement of employment. Contact details of spiritual/religious advisors are available. Resident files include cultural and spiritual values. Residents and relatives interviewed reported that residents can choose to engage in activities and access community resources. Staff attend education and training on abuse and neglect.</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 in the Vines has a Māori health plan that includes a description of how they achieve the requirements set out in the contract. There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. There was one resident who identified as Māori at the time of the audit. The resident's file was reviewed and included Māori cultures and preferences. Links are established with local Iwi and other community representative groups. Cultural needs are addressed in the care plan. Staff interviewed could describe how they can ensure they meet the cultural needs of 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>An initial care planning meeting is carried out where the resident and/or whānau as appropriate/able are invited to be involved. Individual beliefs or values are further discussed and incorporated into the care plan. Six-monthly multidisciplinary team meetings occur to assess if needs are being met. Family are invited to attend. Discussion with relatives confirmed values and beliefs are considered. Residents interviewed confirmed that staff consider their culture and values.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Staff job descriptions include responsibilities and staff sign a copy on employment. The quality improvement meetings occur monthly and include discussions on professional boundaries and concerns as they arise. Management provide guidelines and mentoring for specific situations. Interviews with the village manager, care centre manager, clinical nurse lead and RNs confirmed an awareness of professional boundaries.</p>

<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Residents and relatives interviewed spoke very positively about the care and support provided. Staff have a sound understanding of principles of aged care and stated that they feel supported by the village manager, care centre manager and clinical nurse lead. All Summerset facilities have a master copy of policies which have been developed in line with current accepted best practice and are reviewed regularly. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff. There is a quality improvement programme that includes performance monitoring against clinical indicators and benchmarking against like services within the group as well as other external aged care providers.</p> <p>There is a culture of ongoing staff development with an in-service programme being implemented. There is evidence of education being supported outside of the training plan. There are implemented competencies for caregivers and RNs including but not limited to: insulin administration, medication, wound care and manual handling. RNs have access to external training. A strong teamwork approach, encouraged by positive leadership and regular team building events fosters a culture of good practice.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents and family members stated they were welcomed on entry and were given time and explanation about services and procedures. Family members interviewed also stated they are informed of changes in the health status of residents and incidents/accidents and twelve incident forms sampled confirmed this. Resident/relative meetings are held monthly. The village manager and the care centre manager have an open-door policy. 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/whānau). If residents or family/whānau have difficulty with written or spoken English, the interpreter services are made available.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Summerset in the Vines provides care for up to 43 residents at hospital and rest home level care. On the day of the audit, there were 41 residents in total, 19 residents at rest home level, including one resident under the age of 65 and 22 residents at hospital level, including one resident on an intermediate care contract. All other residents were under the aged residential related care (ARRC) contract. All 43 beds are identified as dual-purpose.</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 in the Vines has a site-specific business plan and goals that is developed in consultation with the village manager, clinical centre manager and regional operations manager. The 2019 business plan was in place and there is a full evaluation at the end of the year. The 2018 evaluation was sighted as reviewed.</p>

		<p>The village manager (non-clinical) has been in the role for three years and has been with Summerset in the Vines for five years. The village manager is supported by a care centre manager and a clinical nurse lead. The care centre manager has been in the position since December 2017 and has considerable background in the health industry (including DHB and aged care). The clinical nurse lead has been in the role for three months. There is a regional operations manager and regional quality manager (present at the time of the audit) who are available to support the facility and staff.</p> <p>The village manager and care centre manager have attended at least eight hours of leadership professional development relevant to the role.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>During a temporary absence, the care centre manager will cover the village manager's role. The regional quality manager provides oversight and support. The audit confirmed the service has operational management strategies and a quality improvement programme to minimise risk of unwanted events.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>Summerset in the Vines is implementing the organisation's 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 'clinical audit, training and compliance' calendar. The calendar schedules the training and audit requirements for the month and the care centre manager completes a 'best practice' sheet confirming completion of requirements. The best practice sheet reports (but is not limited to): meetings held, induction/orientation, audits, competencies and projects and is forwarded to head office as part of the ongoing monitoring programme. A resident satisfaction survey was completed in December 2018 with an overall satisfaction rate of 98% (same as 2017). Corrective actions were implemented around personal cares, meals and activities, evidencing that any suggestions and concerns were addressed.</p> <p>There is a meeting schedule including (but not limited to) monthly quality improvement and staff meetings that include discussion about clinical indicators (eg, incident trends, infection rates). Health and safety, infection control and restraint meetings occur monthly. The service is implementing an internal audit programme that includes aspects of clinical care. Issues arising from internal audits are developed into</p>

		<p>corrective action plans. 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 and staff incidents/accidents. Infection control is also included as part of benchmarking across the organisation. Health and safety internal audits are completed. Summerset's clinical and quality manager analyses data collected via the monthly reports and corrective actions are required based on benchmarking outcomes.</p> <p>There is a health and safety and risk management programme in place including policies to guide practice. A caregiver is the health and safety officer (interviewed with the village manager). The service addresses health and safety by recording hazards and near misses into SWAY, sharing of health and safety information and actively encourage staff input and feedback. Each month there is a health and safety focus topic and staff are provided with resources and education about the topic. The service ensures that all new staff and any contractors are inducted to the health and safety programme. The health and safety programme has been designed around the new legislation. 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.</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>Incident and accident data has been collected and analysed. Twelve resident related incident reports for January 2019 were reviewed. Each event involving a resident reflected a clinical assessment and follow-up by a RN. Neurological observation forms were documented and completed for three unwitnessed falls with a potential head injury. 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.</p> <p>Discussions with the management team confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There has been one section 31 notification completed since the last audit for a stage three pressure injury in August 2018.</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</p>	FA	<p>There are human resources policies to support recruitment practices. A list of practising certificates is maintained. Seven staff files (one care centre manager, one RN, one clinical nurse lead, one diversional therapist and three caregivers) were reviewed and all had relevant documentation relating to employment. All files reviewed included annual performance appraisals for staff who had been employed for longer than one year. A register of RN practising certificates is maintained. Practising certificates for other health practitioners are retained to provide evidence of registration. 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. A full orientation was completed for staff</p>

<p>legislation.</p>		<p>prior to the opening of the service.</p> <p>Staff interviewed could 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 (eg, caregivers, RN and household staff). Core competencies are completed, and a record of completion is maintained on staff files as well as being scanned into 'Sway'. Three of the seven RNs are interRAI trained, including the clinical nurse lead. Staff interviewed were aware of the requirement to complete competency training. Caregivers complete an aged care programme.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a safe staffing policy and procedure, which describes staffing and is based on benchmarking information. Staffing levels and skills mix policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery. The village manager and care centre manager lead, both work 40 hours per week from Monday to Friday and are available on call for any operational issues or clinical support respectively. The clinical nurse lead works four days a week from Monday to Thursday. The service provides 24-hour RN cover.</p> <p>At the time of the audit there were 41 of 43 residents in total (19 rest home and 22 hospital). There are two RNs and seven caregivers (four long and three short shifts) on duty on the morning shift, one RN and six caregivers (three long and three short shifts) on duty on the afternoon shift and one RN, and two caregivers on duty on the night shift. A staff availability list ensures that staff sickness and vacant shifts are covered. Interviews with staff, residents and family members identify that staffing is adequate to meet the needs of residents.</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>	<p>FA</p>	<p>The resident files sampled were appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Other residents or members of the public cannot view sensitive resident information. Resident files are protected from unauthorised access by being held in a locked office. Care plans and notes were legible and where necessary signed (and dated) by a RN. There is an allied health section that contained GP, allied health professionals and specialist's notes involved in the care of the resident.</p>
<p>Standard 1.3.1: Entry To</p>	<p>FA</p>	<p>All residents have a needs assessment completed prior to entry that identifies the level of care required. The care centre manager screens all potential enquiries to ensure the service can meet the required level</p>

<p>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>		<p>of care and specific needs of the resident. Residents and relatives 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 ARRC contract.</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>	<p>FA</p>	<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 and ENs are responsible for the administration of medications for care residents. Senior caregivers' complete competencies for checking and witnessing of medications as required. Medication competencies and education is completed annually. All medications delivered were evidenced to be checked on delivery with any discrepancies fed back to the supplying pharmacy. The service has an electronic medication system. There were no residents self-medicating on the day of audit. Fourteen resident medication charts on the electronic medication system were reviewed.</p> <p>The charts had photograph identification and allergy status recorded. Indications for use were documented in all charts reviewed. All 'as required' medications had an indication for use. The general practitioner had reviewed the medication chart three monthly. There was evidence that all medications (in robotic rolls) were checked on delivery with any discrepancies fed back to the supplying pharmacy. There were no residents self-medicating and RNs interviewed were knowledgeable around monitoring self-medication. All medications were stored appropriately and safely. The controlled drug register evidenced being accurately maintained with weekly checks by two RNs and six monthly by the pharmacist who completes reports around quality improvement suggestions.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p>	<p>FA</p>	<p>Summerset in the Vines has comprehensive nutritional management policies and procedures for the provision of food services for residents. The service has a new contractor for the provision of all meals on-site. The kitchen is adjacent to the dining room. Meals are served from the bain marie to residents in the</p>

<p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>dining room. Meal can be delivered to residents who prefer to remain in their room. The food control plan expires on 19 September 2019. As part of the food safety programme, kitchen fridge/freezer temperatures and food temperatures are recorded and documented at the beginning of the service and when the last meal is served.</p> <p>Food safety training for food services staff has been completed. The seasonal menu has been reviewed by a dietitian. The menu includes the resident preferences and resident dietary requirements. Dislikes are known and accommodated. Special diets such as gluten free, soft diet, pureed meals, high calorie diet and diabetic diet are provided. The service also has an onsite café which is run by the same contractor. Residents and families can purchase meals from the café. The chef manager receives feedback from resident meetings, surveys and welcomes suggestions on the meal service. Residents and family members interviewed commented positively about the food services.</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>	<p>FA</p>	<p>The reason for declining service entry to potential residents should this occur is communicated to the potential resident or family/whānau 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>	<p>FA</p>	<p>The initial support plan is developed with information from the initial assessment and the interRAI home care assessments. Clinical risk assessments are completed on admission where applicable and reviewed six monthly as part of the interRAI assessment. Outcomes of risk assessment tools are used to identify the needs, supports and interventions required to meet resident goals. The service employs seven RNs including the clinical nurse lead and three RNs are interRAI competent.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Although interRAI assessments and care planning were not completed within required timeframes, residents' care plans describe the individual support and interventions required to meet the resident goals and identified needs. Initial risk plans are developed on admission which alert staff to any resident risks such as falls, infections, pressure injury and assistance required for activities of daily living. The long-term care plans reflect the outcomes of risk assessment tools and the interRAI assessments. Care plans demonstrate service integration and include input from allied health practitioners.</p>



		<p>Short-term care plans were in use for changes in health status. These are evaluated regularly 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/families interviewed confirmed they participate in the care planning process. All seven resident records showed documented evidence to support the residents' current needs.</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>FA</p>	<p>The general practitioner highly praised the nursing team and stated that he receives timely referrals and required follow-ups are completed in a timely manner. The GP visits the service at least weekly and more often if required. There is a clinical pharmacist input through the medical clinic during the GP visit. This was documented in the resident's records. When a resident's condition changes, the RN initiates a review and if required a GP or nurse specialist consultation. Relatives interviewed stated their relative's needs are met and they are kept informed of any health changes.</p> <p>There was documented evidence in the resident's progress notes of family notification of any changes to health, including infections, accidents/incidents, medication changes, GP visits and family meetings. Residents interviewed stated their needs are being met. Care plan interventions were comprehensive and included current assessed support needs. Monitoring forms are completed on the electronic resident system. Work logs entered onto the system alert staff of monitoring requirements and these are signed off as completed. Registered nurses review the monitoring charts, which include pain monitoring, neurological observations, bowel monitoring, two hourly re-positioning, restraint/enablers monitoring and food and fluid intake monitoring.</p> <p>Adequate dressing supplies were sighted. Initial wound assessments with ongoing wound evaluations and treatment plans were in place for 15 residents with wounds, of which nine were skin tears (one rest home and eight hospital). The balance of wounds were surgical lesions, one chronic wound and one stage one pressure injury. Wound assessments were completed, and wound care plans were implemented. RNs and caregivers received training around wound care and skin care. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed. There are a number of monitoring forms available for use.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity</p>	<p>FA</p>	<p>The service employs a recreational therapist who is studying towards obtaining her diversional therapist qualification. She works 31 hours per week, Sunday to Thursday. There is also a part time recreational therapist on Saturday and as required. The recreational therapist teleconferences with other Summerset recreational therapists weekly. The programme is prepared a month in advance and are meaningful and relevant for all residents. Rest home and hospital residents join together for the activity programme.</p>

<p>requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>Participation of residents is monitored and documented. There are strong links with community. Group activities reflect ordinary patterns of life and include at least weekly planned visits to the community. All residents in the facility may choose to attend any of the activities offered.</p> <p>Daily contact is made, and one-on-one time is spent with residents who are unable to participate in group activities or choose not to be involved in the activity programme. There are regular van outings for residents (as appropriate), regular entertainment and involvement in community. The activity plans reviewed were well documented and reflected the resident's preferred activities and interests. Each resident has an individual activities assessment on admission and from this information, an individual activity care plan is developed. The activities plans were reviewed six-monthly and aligns with care plan evaluations. Residents and families interviewed stated they enjoy the variety of activities offered and they have input into planning of the programme via daily feedback, resident surveys and at resident meetings.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>All initial care plans were evaluated by the RNs and the long-term care plans were based on outcomes of these evaluations. There is evidence of resident and family involvement in the evaluation of the initial care plan and six-monthly care plan evaluations. Multidisciplinary team reviews have input into the written evaluations, which document whether the resident goals have been met or unmet. The general practitioner completes three monthly reviews. Two out of seven care plans reviewed showed that six monthly care plan evaluations were overdue (link 1.3.3.3).</p>
<p>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.</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 residents' electronic records. 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  Consumers, visitors, and</p>	<p>FA</p>	<p>There are documented policies and procedures for waste disposal and chemical storage. There is a locked cleaner's cupboard and two separate locked sluice rooms. Waste management is part of the environment and equipment audit, which is conducted as part of the quality management programme. During induction, all staff are required to complete training regarding the management of waste. Chemical safety training is a</p>

<p>service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>		<p>component of the compulsory two yearly training and orientation training. Gloves, aprons, and goggles are available in the sluice rooms and in the laundry.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>PA Low</p>	<p>The building has a current building warrant of fitness. A planned and reactive maintenance plan is implemented. Hot water temperatures have been tested and recorded monthly but a number of readings in residents' rooms were over 45 degrees Celsius. The corridors are wide and have safety rails, and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained. All outdoor areas have seating and shade.</p> <p>There is safe access to all communal areas. Caregivers interviewed stated they have adequate equipment to safely deliver care for rest home and hospital level of care residents. Since the previous audit in 2018, the refurbishment programme included two shared bathrooms and five care rooms. The Merlot corridor, sun lounge and Pinot Wing sun lounge has also been included with new artwork, wall painting and furniture. The main resident lounge has been repainted, new curtains, chairs, tables and a storage unit provided.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>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. All bedrooms have a hand basin. Nine bedrooms have ensuites and two rooms have shared ensuite. There are adequate numbers of communal toilets and showers. Communal toilet/shower 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</p>	<p>FA</p>	<p>There is adequate room to safely manoeuvre mobility aids and transferring equipment such as a hoist, as needed for cares and transfer of residents. 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>

areas appropriate to the consumer group and setting.		
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	Communal areas within the facility include a large main lounge and dining room. There are three wings and each of them has separate sitting areas which are open to outdoor areas. There is also an activities room and other sitting areas. The communal areas and outdoors are easily accessible for residents who require a mobility device.
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	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 laundry has defined clean/dirty areas and an entry and exit door. The service employs three staff who undertakes laundry and cleaning services. Cleaning trolleys sighted were well equipped and are kept in designated locked cupboards when not in use. Effectiveness of laundry and cleaning processes are monitored. Material safety datasheets are available and displayed in the cleaning cupboards, laundry and sluice rooms.
<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 is an emergency management and civil defence plan in place to guide staff in managing emergencies and disasters. Emergency equipment is available at the facility. A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. Fire safety and emergency management training is provided to staff. There is appropriate equipment to respond to a fire and other clinical emergencies. Equipment was maintained by the external contractors. There is at least one staff on duty who has a current first aid certificate, however staff who facilitate outings do not have a first aid certificate. Fire evacuation drills have been conducted six monthly with the last fire drill occurring on 29 October 2018.</p> <p>Civil defence and pandemic/outbreak supplies are available and are checked three monthly. Staff emergency and disaster management training is provided to staff. There is sufficient water stored (two water tanks and well water) to ensure ten litres per resident for three days. Alternative heating and cooking facilities (BBQ and portable gas cooker) are available in the event of a power failure. There is emergency back-up lighting available for up to four hours. Smoke alarms, sprinkler system and exit signs are in place. The facility is secured at night. There are call bells in all resident rooms and communal areas. Visitors and contractors sign in at reception when visiting.</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 shows 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.</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>	FA	<p>There are comprehensive infection control policies. The infection prevention and control coordinator is an RN supported by the care centre manager and the infection control committee. Quality improvement and staff meetings include infection control data and surveillance activities. There is a monthly benchmarking of infections conducted for all Somerset facilities. There are clear lines of accountability to report to the infection control committee on any infection control issues including a reporting and notification of infections. All staff complete infection control education on orientation and annually as part of the education planner. The 2018 infection control programme has been reviewed and there are infection control goals in place for 2019. Infection control committee meetings are scheduled monthly but occurred intermittently (link 3.2.1).</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>	PA Low	<p>The infection control committee comprises of a cross section of staff from areas of the service. The infection control committee meetings were scheduled monthly, however meetings took place intermittently. The facility has access to an infection control nurse specialist at the DHB, public health authorities, laboratory, general practitioners and experts within the organisation. Infection events are forwarded to head office for benchmarking.</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</p>	FA	<p>There are comprehensive infection control policies that are current and reflect the Infection Control Standard SNZ HB 8134:2008, legislation and good practice. The infection control policies link to other documentation and cross reference where appropriate.</p>

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.		
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection prevention and control coordinator and the care centre manager are responsible for coordinating and providing education and training to staff. Ongoing training occurs annually as part of the training calendar and resident education occurs as part of providing daily cares. Care plans included infection prevention and control interventions as appropriate. Staff received training related to infection control and prevention, hand hygiene and outbreak management in 2018.
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	There is a policy describing surveillance methodology for monitoring of infections. Surveillance programme is implemented and is appropriate to the size and complexity of the facility. Infection events are entered into the electronic patient management system and extracted monthly onto the share point electronic system. The infection prevention and control coordinator provide infection control data, trends and relevant information to the infection control committee and clinical/quality meetings. There is also a quality initiative in place with the aim of reducing urinary infections. This is currently ongoing.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	There are policies around restraints and enablers. The service currently has eight residents assessed as requiring the use of restraint (three bedrails and five lapbelts) and five requiring an enabler (bedrails). The care plans are up to date and provide the basis of factual information in assessing the risks of safety and the need for restraint. Ongoing consultation with the resident and family/whānau is also identified. Residents voluntarily request and consent to enabler use. Staff receive training around restraint minimisation that last occurred in September 2018.
Standard 2.2.1: Restraint approval and processes Services maintain a process	FA	A restraint approval process and a job description for the restraint coordinator are in place. The restraint coordinator role is delegated to an RN. All staff are required to attend restraint minimisation training annually.

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.		
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	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. Three resident files where restraint was being used were reviewed. The files included a restraint assessment and consent form that was signed by the resident's family. The completed assessment considered those listed in 2.2.2.1 (a) - (h).
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	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 identified that restraint is being used only as a last resort. The restraint assessment and ongoing evaluation of restraint use process includes reviewing the frequency of monitoring residents while on restraint. Monitoring forms are completed when the restraint is put on and when it is taken off.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Restraint use is reviewed monthly during the quality improvement meetings. The review process includes discussing whether continued use of restraint is indicated.
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.

## 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 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	PA Low	<p>Seven resident records were reviewed (three rest home and four hospital). All initial assessments and care plans were completed within 24 hours entry to the service. Four residents were recent admissions (two rest home and two hospital) and care plan evaluations were not due. One rest home and one hospital residents' records showed that care pan evaluations were not completed six monthly. The remaining file had six monthly care plan evaluations completed within identified timeframes.</p> <p>InterRAI assessments were also not always completed within 21 days of entry to the service (two rest home and two hospital residents). Six monthly interRAI assessments were completed in a timely manner and four residents were new admissions, therefore they were not due. Four residents' records showed that (two rest home and two hospital) long-</p>	InterRAI assessments, long-term care plans and care plan evaluations were not always completed within identified timeframes.	<p>Ensure that interRAI assessments, care plans and care plan evaluations are completed within required timeframes.</p> <p>90 days</p>



		term care plans were developed after 21 days. The time gap varied between seven days to two months.		
<p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p>	PA Low	<p>The building has a current building warrant of fitness that expires on 26 February 2020. There is a full-time property manager and a part time maintenance person who undertakes property management and gardening services. There are also a number of contractors who provide maintenance services.</p> <p>Planned and reactive maintenance systems are in place and maintenance requests are generated through the Sway (Somerset way) on-line system (property services requests). All electrical equipment has been tested and tagged. Clinical equipment has had functional checks/calibration annually. Hot water temperatures have been tested and recorded monthly but a number of readings in resident's rooms were over 45 degrees Celsius.</p>	<p>Hot water monitoring occurs. Review of hot water recording in residents' rooms showed fluctuation of temperatures between 46 to 50 degrees Celsius, but there was no documented follow-up ensuring that the hot water is maintained within 45 degrees Celsius.</p>	<p>Ensure that hot water temperature at tap is maintained around 45 degrees Celsius.</p> <p>60 days</p>
<p>Criterion 1.4.7.1</p> <p>Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.</p>	PA Low	<p>Fire safety and emergency management training is provided to staff. There is appropriate equipment to respond to a fire and other clinical emergencies. Equipment was maintained by the external contractors. There is at least one staff on duty who has a current first aid certificate, however staff who facilitate outings do not have a first aid certificate.</p>	<p>Activities staff and caregivers who facilitate outings do not have a current first aid certificate.</p>	<p>Ensure that staff who facilitate outings have a current first aid certificate.</p> <p>90 days</p>
<p>Criterion 3.2.1</p> <p>The infection control team/personnel and/or committee shall comprise, or have access to, persons with the range of</p>	PA Low	<p>The infection control committee comprises of a cross section of staff from areas of the service. The infection control committee meetings were scheduled monthly, but meetings took place intermittently. The infection prevention and control coordinator is new in her role and supported by the care centre manager who had infection prevention and</p>	<p>Infection control meetings are scheduled monthly but meetings occurred intermittently. There were no meetings between May to October 2018 due to lack of</p>	<p>Ensure that infection control meetings take place as scheduled.</p>

skills, expertise, and resources necessary to achieve the requirements of this Standard.		control advisory role in her previous employment. The infection prevention and control coordinator completed online training.	quorum (staff availability).	90 days
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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.

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End of the report.