

Summerset Care Limited - Summerset in the River City

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:

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| Legal entity: | Summerset Care Limited |
| Premises audited: | Summerset in the River City |
| Services audited: | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) |
| Dates of audit: | Start date: 4 March 2019 End date: 5 March 2019 |
| Proposed changes to current services (if any): | |
| Total beds occupied across all premises included in the audit on the first day of the audit: | 39 |

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

| Indicator | Description | Definition |
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|  | 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 |
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| | 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 River City provides rest home and hospital level care for up to 37 residents in the care centre and up to 12 rest home residents in the serviced apartments. On the day of the audit there were 39 residents. The service is managed by a village manager and care centre manager. The residents and relatives interviewed spoke positively about the care and support provided.

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 village manager is appropriately qualified and experienced and is supported by a care centre manager (registered nurse) who oversees the care centre and rest home residents in the serviced apartments. There are quality systems and processes being implemented. An induction and in-service training programme are in place to provide staff with appropriate knowledge and skills to deliver care.

The service is commended for achieving three continued improvement ratings around good practice, restraint free environment and reduction of urinary tract infections.

Consumer rights

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

Organisational management

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| 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 River City has a well-established quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to a number of meetings including monthly quality improvement meetings. Annual surveys and monthly resident meetings provide residents and families with an opportunity for feedback about the service. Quality performance is reported to staff at meetings and includes discussion about incidents, infections and internal audit results. There are human resources policies including recruitment, selection, orientation and staff training and development. The service

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

Continuum of service delivery

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| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. | | Standards applicable to this service fully attained. |
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Residents are assessed prior to entry to the service and a baseline assessment is completed upon admission. Registered nurses are responsible for care plan development with input from residents and family. Long-term care plans reviewed were completed within policy timeframes. Residents and family interviewed confirmed that the care plans are consistent with meeting residents' needs. Planned activities are appropriate to the resident's assessed needs and abilities and residents advised satisfaction with the activities programme. Medications are managed and administered in line with legislation and current regulations. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

Safe and appropriate environment

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| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. | | Standards applicable to this service fully attained. |
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Summerset in the River City has a current building warrant of fitness. Reactive and preventative maintenance is carried out. Chemicals are stored securely, and staff are provided with personal protective equipment. Hot water temperatures are monitored and recorded. Medical equipment and electrical appliances have been calibrated by an authorised technician. Residents' rooms

are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. There are sufficient communal areas within the facility including lounge and dining areas, and small seating areas. There is a designated laundry and cleaner's room. The service has implemented policies and procedures for civil defence and other emergencies and six-monthly fire drills are conducted. External garden areas are available with suitable pathways, seating and shade provided. Smoking is only permitted in designated external areas.

Restraint minimisation and safe practice

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| <p>Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.</p> | | <p>All standards applicable to this service fully attained with some standards exceeded.</p> |
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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. The service is restraint free. Staff receive regular education and training on restraint minimisation.

Infection prevention and control

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| <p>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.</p> | | <p>All standards applicable to this service fully attained with some standards exceeded.</p> |
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The infection control programme is appropriate for the size and complexity of the service. The infection control coordinator (RN) is responsible for coordinating and providing education and training for staff. The infection control coordinator has attended external training. The infection control manual outlined the scope of the programme and included a comprehensive range of policies and guidelines. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This included audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other 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) |
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| Standards | 3 | 42 | 0 | 0 | 0 | 0 | 0 |
| Criteria | 3 | 90 | 0 | 0 | 0 | 0 | 0 |

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

Attainment against the Health and Disability Services Standards

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

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

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

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

| Standard with desired outcome | Attainment Rating | Audit Evidence |
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| <p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p> | FA | <p>Discussions with eight care staff (five caregivers, two registered nurses (RN), and one diversional therapist) confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Six residents (three hospital and three rest home including one resident in the serviced apartments, one younger person and one intermediate care resident) and five relatives (four hospital and one rest home) were interviewed and confirmed the services being provided are in line with the Code. All staff complete competencies around Code of Rights. Observation during the audit confirmed this in practice.</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</p> | FA | <p>Informed consent and advanced directives were recorded as evidenced in six of seven resident files reviewed (the seventh file of a resident on an intermediate contract had informed consent on file). Family involvement occurs with the consent of the resident. Residents interviewed confirmed that information was provided to enable informed choices and that they were able to decline or withdraw their consent. Resident admission agreements were signed.</p> |

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| consent. | | |
| <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 | Residents are provided with a copy of the Code of Right and access to advocacy services 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. Code of Rights and advocacy is discussed with residents and relatives on admission to the service. A health and disability advocate attends the friends/family and resident three-monthly meetings. Meeting minutes are displayed on the resident noticeboard. The service provided opportunities for the family/enduring power of attorney (EPOA) to be involved in decisions as evidenced in the resident files reviewed. The resident files include information on residents' family/whānau and chosen social networks. |
| <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 | Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. Activities programmes included opportunities to attend events outside of the facility including activities of daily living, for example, shopping and attending cafés and restaurants. Interviews with staff, residents and relatives informed residents are supported and encouraged to remain involved in the community and external groups. Relative and friends are encouraged to be involved with the service and care. |
| <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 | The organisational complaints policy states that the village manager has overall responsibility for ensuring all complaints (verbal or written) are fully documented and investigated. There is a complaint register that included relevant information regarding the complaint. Documentation included acknowledgement, investigation, follow-up letters (offering advocacy) and resolution. There were three complaints received in 2018. All of the complaint's documentation were completed within the required timeframes. There was evidence of action plans including education provided by the regional manager on the deteriorating resident. Complaints and concerns are discussed at the relevant facility meeting. A complaints procedure is provided to residents within the information pack at entry. Feedback forms are available for residents/relatives at the main entrances to both buildings. |
| <p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed</p> | FA | The service provides information in the welcome pack 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. The Code of Rights (in English and Māori) are displayed at the main entrance of both buildings. Monthly resident meetings and the annual residents/relatives survey is completed and provides an opportunity |

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| of their rights. | | to raise concerns. |
| <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 were able to 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 are able to choose to engage in activities, access community resources and are supported to attend church services. Staff were observed knocking on resident doors before entering the room. There is an elder abuse and neglect policy. Staff receive 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 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. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with a local kaumātua who is readily available for resident, family and staff support. There are Māori staff including caregivers who facilitate Tikanga for the four Māori residents who identify with Māori. Two of four Māori resident files reviewed had Māori Health plans that acknowledged the importance of tribal affiliation, whānau involvement te reo Māori and Tikanga. Two Māori staff interviewed stated they are actively involved in the review of Māori Health plans and represent/support Māori residents as requested by the resident/family. Staff interviewed were able to describe how they can ensure they meet the cultural needs of residents identifying as Māori. Treaty of Waitangi and cultural safety was last provided in December 2018 with 35 staff attending. The service aims to have at least one Māori staff member on duty each shift to provide support for the Māori residents.</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</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 multi-disciplinary 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 take into account their culture and values.</p> |

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| respect their ethnic, cultural, spiritual values, and beliefs. | | |
| <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 for all staff occur monthly and include discussions on professional boundaries and concerns as they arise. Management provide guidelines and mentoring for specific situations. Interviews with the care centre manager, clinical nurse leader and registered nurses confirmed an awareness of professional boundaries. Registered nurses (RN) attended Code of Conduct/professional boundaries in-service December 2018. Caregivers and RNs interviewed were knowledgeable around the scope of their role and responsibilities.</p> |
| <p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p> | CI | <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 and care centre manager.</p> <p>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 is undertaken. There is a culture of ongoing staff development with an in-service programme being implemented. Caregivers, once orientation has been completed, hold level two Careerforce unit standards. There is evidence of education being supported outside of the training plan. Registered nurses are linked to the DHB professional development recognition programme (PDRP). Services are provided at Summerset that adheres to the Health & Disability services standards. There are implemented competencies for caregivers and registered nurses specific to their roles.</p> <p>The service has evidenced good practice and achieved a continuous improvement around weight loss management.</p> |
| <p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective</p> | FA | <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 resident's health status and incidents/accidents as evidenced in 14 accident/incidents reviewed on the electronic register. Resident/relative meetings are held monthly with an advocate from Age Concern present at the meeting every three months. The village manager and the care centre manager have an open-door policy. The service produces a newsletter for residents and relatives.</p> <p>Residents and family are advised in writing of their eligibility and the process to become a subsidised resident</p> |

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| communication. | | 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. Caregivers interviewed could describe how they communicated with one resident who did not speak English with the use of cue cards and body language to meet the resident needs. |
| <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> | FA | <p>The service provides care for up to 37 residents at hospital and rest home level care in the care centre. There are 12 serviced apartments certified for rest home level of care in a separate building. On the day of the audit, there were 34 residents in the care centre with 14 at rest home level (including one younger person and one under intermediate care contract) and 20 hospital level including three under the intermediate care contract. There were five rest home residents in the serviced apartments.</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 River City has a site-specific business plan and goals that is developed in consultation with the village manager, care centre manager and regional quality manager. The Summerset in the River City quality plan is reviewed quarterly throughout the year. The 2018 evaluation was sighted and there is a 2019 village plan in place that includes key priorities such as increase in resident satisfaction survey, falls prevention, polypharmacy, event management (activities), food services and a focus on providing a dementia friendly service.</p> <p>The village manager has been in the current role at Summerset since November 2017 and was previously at another Summerset site. The village manager was on leave on the days of audit and a relieving village manager and regional quality manager were on site to support staff with the audit process. The village manager has attended a two-day Summerset conference. The village manager is supported by a care centre manager/RN. He has been with Summerset since 2012 as an RN and was appointed to the care centre manager role in July 2017. A care centre manager orientation has been completed and he has attended “leading the walk” dementia course and holds proficient level for the DHB professional development recognition programme. The care centre manager is supported by a clinical nurse leader.</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</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> |

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| <p>ensures the provision of timely, appropriate, and safe services to consumers.</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> | <p>FA</p> | <p>Summerset in the River City 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 from head office. The content of policy and procedures are detailed to allow effective implementation by staff. Staff are required to read and sign for new/reviewed policies.</p> <p>The Summerset group has a 'clinical audit, training and compliance' calendar. The calendar schedules the training and audit requirements for the month. The village manager and care centre manager complete monthly reports confirming completion of requirements. There is a meeting schedule including monthly quality improvement (all staff) meetings, registered nurse meetings and care staff meetings. The infection control coordinator provides a monthly report and health and safety committee meetings are held. There are other facility meetings held, such as kitchen and activities. Quality data such as infections, accidents/incident, hazards, audit outcomes, concerns/complaints are discussed and documented in meeting minutes. Meeting minutes and quality data reports and graphs are available to all staff. An annual residents/relatives survey completed October 2018 reports 97% overall satisfaction rate. An action plan for 2019 has been developed identifying areas for improvement around activities and food service. The results have been communicated to residents at the February 2019 resident meeting.</p> <p>The service is implementing an internal audit programme that includes environmental, infection control, health and safety, consumer rights and aspects of clinical care. Issues arising from internal audits are developed into corrective action plans and re-audits as required. Monthly and annual analysis of results is completed and communicated to all staff.</p> <p>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. Summersets clinical and quality manager analyses data collected via the monthly reports and corrective actions are required based on benchmarking outcomes. The regional quality manager is alerted automatically through the RMSS system of any high-level accident/incidents (resident, staff and environmental).</p> <p>There is a health and safety and risk management programme in place including policies to guide practice that is generated from the national health and safety committee. Support is provided by the national health and safety manager who completes a comprehensive internal audit of the facility. The service has a health and safety representative (interviewed) with health and safety level 1 and 2 qualifications. The health and safety</p> |

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| | | <p>committee meet monthly and review incidents/accidents/hazards and near misses. The committee provides a monthly report to management and the quality improvement meeting. Each month there is a focus on one of the golden rules of safety. All staff and contractors receive a health and safety induction. The hazard register has been updated February 2019.</p> <p>Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls. Fall prevention strategies are documented in individual care plans and include meeting resident's needs (fluids, toileting), two hourly checks, activities, exercises, physiotherapy input, pharmacy reviews, staff education and use of sensor mats and hip protectors. There has been a decrease of 12 falls (53 falls) for the first quarter of 2019 compared to the average quarter for 2017 - 2018 at 65 falls per quarter (link CI 2.1.1.4).</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 have been collected and analysed. Fourteen resident related incident reports for December 2018 were reviewed (including three unwitnessed falls, eight skin tears, one bruise and two wandering). All reports and corresponding resident files reviewed evidenced that appropriate clinical care has been provided following an incident and the relative had been notified. The incident reporting policy includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Data is linked to the organisation's benchmarking programme and used for comparative purposes. Discussions with the relieving village manager and regional quality manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. The MOH and DHB were notified of the change in village manager and care centre manager in 2017. There have been no other notifications to report. There have been no outbreaks to report.</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> | FA | <p>There are human resources policies to support recruitment practices. A list of RN and allied health practising certificates is maintained. Eight staff files (one care centre manager, one clinical nurse leader, two RNs, two caregivers, one diversional therapist and one housekeeper) were reviewed and all had relevant documentation relating to employment. Performance appraisals had been completed annually. The service has an orientation programme in place for each role that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and believed new staff were adequately orientated to the service. Caregivers are level two of Careerforce once they have completed their orientation booklet. The care centre manager and CNL are Careerforce assessors. There is an annual education plan that is outlined on the 'clinical audit, training and compliance calendar'. The plan has been completed for 2018 and commenced for 2019. Education is held at the monthly staff meetings. There are good attendance numbers and sessions are repeated to capture staff who did not attend the meeting. The training programme is flexible enough to add additional in-services relevant to the service. Care staff and RNs have completed palliative care education from hospice. External education is also provided, and RNs are linked to the PDRP at the DHB. Five</p> |

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| | | <p>RNs have completed interRAI training.</p> <p>A competency programme is in place with different requirements according to work type (eg, caregivers, registered nurse and kitchen). Core competencies are completed, and a record of completion is maintained on staff files and on-line. An RN assessor provides manual handling education and staff complete competencies.</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> | FA | <p>The village manager and care centre 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 is a CNL on Sunday to Thursday and a senior RN covers the days off. There is an additional RN on morning shift two days a week.</p> <p>There are five caregivers on morning shifts (three full shift and two short shifts), four on the afternoon (two full shift and two short shift) and two caregivers on the night shift in the care centre. One caregiver with a first aid certificate is allocated to attend emergency calls in the village.</p> <p>The serviced apartments are in a separate building and there is a caregiver on duty 24 hours. The care centre RN is allocated to one full day per week to the rest home residents in the serviced apartments. The RN each day visits the serviced apartments at handover. On shifts where there is one RN on duty (afternoons and nights) the on-call RN is contacted.</p> <p>There is a recreational therapist seven days a week.</p> <p>The serviced apartment caregiver's complete laundry for the service. There are designated housekeepers.</p> <p>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. Relatives and residents confirmed there were sufficient staff on duty.</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 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. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Electronic resident files are password protected from unauthorised access. Individual resident files demonstrate service integration.</p> |
| <p>Standard 1.3.1: Entry To</p> | FA | <p>The service had comprehensive admission policies and processes in place. Residents receive an information booklet around admission processes and entry to the service. The care manager screens all potential residents</p> |

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| <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>prior to entry to services to confirm they meet the level of care provided at the facility. Residents and relatives interviewed confirmed they received information prior to admission and discussed the admission process and admission agreement with the village manager/care manager.</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>The transfer/discharge/exit procedures include a transfer/discharge form and the completed form is placed on file. The service stated that a staff member escorts the resident if no family are available to assist with transfer, and copies of documentation are forwarded with the resident.</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>The service uses an electronic charting and administration system and individualised robotic medication rolls which are checked in on delivery. Two registered nurses were observed administering medications correctly (in the apartments a medication competent caregiver administers medications). Medications and associated documentation were stored safely and securely, and all medication checks were completed and met requirements. Resident photos and documented allergies or nil known were on all 14 medication charts reviewed. An annual medication administration competency is completed for all staff administering medications and medication training has been conducted.</p> <p>There is a self-medicating resident's policy and procedures in place. There was one YPD resident self-administering an inhaler and topical medications. Competency had been tested. Standing orders were not used. All medication charts reviewed recorded indication for use of 'as required' medication by the GP. 'As required' medication is reviewed by a registered nurse each time prior to administration, pain assessments were undertaken before administering 'as required' analgesia. Medication charts reviewed identified that the GP had reviewed the resident three monthly.</p> |
| <p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual</p> | <p>FA</p> | <p>An external company is contracted for the provision of meals on-site. There is an eight-week rotating menu approved by the dietitian. The verified food control plan expires April 2019. There are alternative meal options available and resident likes/dislikes and preferences are known and accommodated. Special diets include diabetic and pureed meals as assessed for residents by the RN. The cook receives a dietary profile for each</p> |

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| <p>food, fluids and nutritional needs are met where this service is a component of service delivery.</p> | | <p>resident. Supplements are provided to residents with identified weight loss issues. Weights are monitored monthly or more frequently if required and as directed by a dietitian. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed indicated satisfaction with the food service.</p> <p>The kitchen is well equipped. The fridge, freezer and dishwasher have daily temperatures recorded. End cooked food temperatures are recorded daily. Cleaning schedules are maintained. Chemicals are stored safely within the kitchen which is locked after hours. Staff were observed wearing correct personal protective clothing. Staff working in the kitchen have food handling certificates and chemical safety training.</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 service records the reason for declining service entry to residents should this occur and communicates this to residents/family/whānau. Anyone declined entry is referred back to the needs assessors or referring agency for appropriate placement and advice.</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>All appropriate personal needs information is gathered during admission.</p> <p>In the files reviewed, the interRAI assessment tool had been used for all residents admitted under the ARRC agreement. A nursing assessment and care plan were completed on admission. As well as using interRAI assessments, the residents' files also included a full range of assessments to assist with resident care planning. Files reviewed identified that risk assessments have been completed on admission and reviewed six monthly as part of the evaluation.</p> |
| <p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote</p> | <p>FA</p> | <p>The long-term care plan (which is electronic) includes nursing diagnosis, actual or potential/deficits, outlined objectives of nursing care, setting goals, and details of implementation. Resident/family/whānau involvement in the care planning process was evident. Residents and relatives interviewed, and resident files sampled, confirmed that resident/family were involved in the development/evaluation of care plans. Short-term care plans were in use for changes in health status including weight management, wounds and falls management.</p> |

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| continuity of service delivery. | | |
| <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> | FA | <p>A record of each resident's progress is documented. Changes are followed up by a registered nurse. When a resident's condition alters, the registered nurse initiates a review and if required, a GP consultation or referral to the appropriate health professional is actioned. The clinical staff interviewed advised that they have all the equipment referred to in care plans necessary to provide care. Dressing supplies are available and treatment rooms are well stocked for use. Wound documentation was reviewed and included wound assessment, treatment plans and evaluations and progress notes for all wounds (including one laceration, one surgical wound, two chronic wounds, an abrasion, four skin tears, one resident with incontinence associated dermatitis and one other). Wound care nurse specialist advice is readily available, and photos are taken of all chronic wounds and a separate short-term care plan is generated for each wound. Continence products are available and specialist continence advice is available as needed. Short-term care plans with interventions and ongoing evaluations by the RN were evidenced. A physiotherapist referral is initiated if required and assessment of any equipment 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> | FA | <p>The activities staff (a qualified diversional therapist and one in training) provide an activities programme over seven days each week. The programme is planned monthly and residents receive a personal copy of planned monthly activities. Activities plan for the month are displayed in large style colour format on noticeboards around the facility. A diversional therapy plan is developed for each individual resident based on assessed needs. Residents are encouraged to join in activities that are appropriate and meaningful and are encouraged to participate in community activities. The service has a van that is used for resident outings and a car that is used for resident transport. Residents were observed participating in activities on the days of audit. Resident meetings (monthly) provide a forum for feedback relating to activities. Residents who are unable to or choose not to participate are visited for one-on-one discussions and activities at least weekly. Residents and family members interviewed discussed enjoyment in the programme and the diversity offered to all residents.</p> <p>The YPD resident, on interview, stated they enjoy joining in with all the activities offered on the programme and attending the residents meeting. They also have outings with groups, including going to a church group and the DT provides materials so individual activities can be undertaken when they choose.</p> |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are</p> | FA | <p>Care plans reviewed were updated as changes were noted in care requirements. Care plan evaluations are comprehensive, related to each aspect of the care plan and recorded the degree of achievement of goals and interventions. Short-term care plans are utilised for residents and any changes to the long-term care plan were dated and signed. Short-term care plans were in use. Care plans are evaluated within the required timeframes.</p> |

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| evaluated in a comprehensive and timely manner. | | |
| <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> | FA | <p>The service facilitates access to other services (medical and non-medical) and where access occurred, referral documentation is maintained. Residents' and or their family/whānau are involved as appropriate when referral to another service occurs.</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> | FA | <p>Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Material safety datasheets were readily accessible for staff. Chemical bottles sighted have correct manufacturer labels. Chemicals are stored safely throughout the facility. Personal protective clothing is available for staff and seen to be worn by staff when carrying out their duties on the day of audit.</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</p> | FA | <p>The care centre and serviced apartments (two separate buildings) have a current warrant of fitness that expires on 2 February 2020. There is a full-time property manager who is available on call for facility matters. Planned and reactive maintenance systems are in place. All electrical equipment is on a schedule for testing and tagging and due in July 2019. Clinical equipment is on a schedule for calibration and checking, next scheduled for April 2019. Hot water temperatures have been tested and are on a monthly schedule with readings between 42-45 degrees Celsius. Preferred contractors are available 24/7.</p> <p>Corridors are wide in all areas to allow residents to pass each other safely. There is safe access to all communal areas and outdoor areas. There is outdoor seating and shade. There is a designated smoking area</p> |

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| purpose. | | <p>for residents who smoke.</p> <p>The caregivers and registered nurses (interviewed) stated they have all the equipment required to provide the care documented in the care plans. The following equipment is available: electric beds, ultra-low beds, air alternating mattresses, sensor mats, standing and lifting hoists, mobility aids and wheel-on weigh scales.</p> <p>There is a large reception area in the serviced apartments that care staff utilise as an office including secure storage for medications and treatment supplies.</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> | FA | <p>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. Six bedrooms have an ensuite with two other rooms sharing an ensuite. The remainder of resident rooms all have a hand basin and share bathroom and toilet facilities. There are communal toilets located near the lounge/dining rooms. Communal toilet and 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 areas appropriate to the consumer group and setting.</p> | FA | <p>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>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> | FA | <p>There is a large lounge and dining room, and two conservatories within the care part of the facility. The dining room is spacious, and located directly off the kitchen/servery area. All areas are easily accessible for the residents. The furnishings and seating are appropriate for the consumer group. Residents interviewed reported they were able to move around the facility and staff assisted them when required. Activities take place in the</p> |

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| <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p> | | <p>lounge.</p> <p>In the serviced apartment building there is a large cafe and lounge area. Rest home residents in the apartments utilise these areas, and if they wish they can have their meals delivered directly to their own units. Meals delivered from the care facility to rest home residents in the apartment building are done so in hot boxes.</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. The laundry has a dirty to clean work flow. There are dedicated housekeeping staff and the laundry is undertaken by apartment caregiving staff. All linen and personal clothing was laundered onsite. Cleaning trolleys are kept in designated locked cupboards. Residents and family interviewed reported satisfaction with the cleaning and laundry service. Internal audits monitor the effectiveness of the cleaning and laundry processes.</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> | <p>FA</p> | <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 in the River City has an approved fire evacuation plan and fire drills occur six monthly. The village manager developed a comprehensive evacuation plan and training that was more specific to the site with its three buildings (care centre, leisure centre and serviced apartment) and three fire systems. The training plan is used for orientation and staff training. The service has been able to meet fire evacuation compliance following the evacuation plan. The service has alternative cooking facilities with barbeques and gas bottles available in the event of a power failure. A generator is available from the Palmerston North facility. Emergency battery backup is available for emergency lights and the call bell system. There is adequate food available at all times for at least three days and a 10,000-litre water tank onsite. Call bells were evident in residents' rooms, lounge areas and toilets/bathrooms. The facility is secured at night with call bell access at the front doors. The village is secure with main gates that are locked after hours with access for village residents and emergency services.</p> |
| <p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and</p> | <p>FA</p> | <p>Visual inspection evidences that the residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p> |

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| <p>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> | <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 (RN) 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.</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>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 has been in the role six months. She has a graduate certificate in infection prevention and control (2012) and recently attended an infection control DHB workshop. There are monthly “zoom” meetings with all Summerset infection control officers.</p> <p>The infection control team comprises of a cross section of staff from areas of the service. The infection control team meet monthly and provide a report to the quality improvement meeting.</p> <p>The infection control team has access to an infection control nurse specialist at the DHB, laboratory, pharmacy, GPs and expertise within the organisation. The regional quality manager oversees infection control across the facilities.</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 are readily available and are</p> | <p>FA</p> | <p>Policies and procedures are developed and reviewed at head office. Policies are available to all staff. They are notified of any new/reviewed policies and are required to read and sign for these.</p> |

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| 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 control officer is responsible for coordinating and providing education and training to staff. The induction package includes specific training around handwashing competencies and standard precautions. Ongoing training occurs annually as part of the training calendar set at head office. Resident education occurs as part of providing daily cares. Care plans can include ways to assist staff in ensuring this occurs. |
| Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | CI | 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 into the 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. A urinary tract infection (UTI) reduction plan was commenced to reduce UTIs which has been successful. The facility is benchmarked against other Somerset 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. Reports and graphs are displayed on the staffroom infection control noticeboard. There have been no outbreaks. |
| Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised. | CI | There are policies around restraints and enablers. The service has no residents on restraint or with enablers. Alternative strategies and effective falls prevention strategies have ensured the facility remains restraint free since January 2018. Staff receive training around restraint minimisation that includes annual competency assessments. The restraint coordinator (CNL) oversees restraint minimisation for the service. |

Specific results for criterion where corrective actions are required

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

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

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

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Specific results for criterion where a continuous improvement has been recorded

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

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

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

| Criterion with desired outcome | Attainment Rating | Audit Evidence | Audit Finding |
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| <p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p> | CI | <p>The service provides an environment that encourages good practice beyond the expected full attainment. The service has conducted quality improvement projects to support Summerset “do no harm” component as part of its commitment to improving resident care. There is evidence of action taken based on findings that has made improvements to service provision and resident care for unintentional weight loss.</p> | <p>A “food first” programme was implemented based on the DHB dietitian recommendations and provided options for high calorie every day foods or ingredients. Residents identified with any unintentional weight loss are offered at least two choices of high calories foods per day such as added cream to cereals/porridge, ice-cream to desserts, milk-based desserts, yoghurts and fortified milkshakes. The service appointed a weight management champion who reviews weight data weekly, including the weekly weighs of residents on the “food first” programme and liaises regularly with the dietitian. Residents who do not gain weight despite the additional high calorie foods are referred to the dietitian and GP for review. Staff education around food and hydration and the principles of “food first” was completed August 2018 at the commencement of the programme. Three residents currently on the “food first” programme monitoring reports and weekly weights reviewed demonstrated the “food first” action plan had resulted in weight gain with one gaining 8kg over 6 months, one gaining 4.7kg over three months and another gaining 1.7kg over one month.</p> |

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| <p>Criterion 3.5.7</p> <p>Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p> | <p>CI</p> | <p>A project for the reduction of urinary tract infections (UTI) by 20% was commenced following an increase in UTIs in October 2018. The service has been successful in reducing the incidence of UTIs.</p> | <p>The infection control coordinator (RN) developed a project action plan for the reduction of UTIs in consultation with the infection control committee. The action plan included infection control education around hand hygiene, use of personal protective wear, hydration and continence management. Sessions were repeated and demonstrate 100% attendance. Regular fluid rounds and toileting continued. Trends and analysis of infections for individual residents identified cause, treatment and management of UTIs which was reflected in the residents' care plans. Infection data is discussed at the monthly management and clinical meetings and care staff interviewed could describe the signs and symptoms of UTI that they would report to the RN. In December there was a spike in UTIs (five) with three of five residents prone to UTIs (one with an indwelling catheter). Laboratory results are received and identify any sensitivities and resistance to the prescribed antibiotics. The GP liaises with the service in the management of all UTIs. The service has been successful in reducing the incidence of UTIs by 78% over a five-month period from October 2018 to February 2019.</p> |
| <p>Criterion 2.1.1.4</p> <p>The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.</p> | <p>CI</p> | <p>The service has been successful in maintaining a restraint free environment without compromising resident safety from January 2018 to date.</p> | <p>Alternative strategies are implemented on an individual basis for all residents at risk of falls and residents with challenging behaviours. These include ensuring resident care needs are met (fluids, re-positioning, toileting), call bells within reach and resident involvement in activities. There have been two restraint minimisation trainings per year, restraint competencies and restraint audits completed. Staff interviewed were knowledgeable in restraint minimisation and alternative strategies. The service developed a pamphlet for families and residents on minimising restraints which is included in the welcome information pack. There has been an increase in hospital level residents over the last year and there have been no incidents that relate to not having a restraint in place. The number of falls have not increased due to being a restraint free environment and have decreased by 12 falls this quarter in comparison to the first quarter of 2018. The service has been successful in maintaining a restraint free environment over the last year to date.</p> |

End of the report.