

Summerset Care Limited - Summerset By the Sea

Introduction

This report records the results of a Certification Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	Summerset Care Limited
Premises audited:	Summerset by the Sea
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 2 July 2019 End date: 3 July 2019
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	38

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
Yellow	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
Red	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 by the Sea provides rest home and hospital level care for up to 49 residents in the care centre and up to 20 rest home residents in the serviced apartments. On the day of the audit there were 38 residents in the care centre and no rest home residents in the serviced apartments. 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 service is managed by a village manager who has been in the role three years and a care centre manager (RN) who has been in the role 10 weeks. The management team is supported by a regional operations manager and regional quality manager.

This audit identified areas for improvement around performance appraisals, service provision timeframes, care plans interventions, medicine management, first aid training and restraint documentation.

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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Summerset by the Sea 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

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Summerset by the Sea has a quality and risk management system in place. Key components of the quality management system link to a number of meetings including monthly quality improvement meetings. Annual surveys and 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

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Residents are assessed prior to entry to the service and a baseline assessment is completed upon admission. The registered nurses are responsible for each stage of provision of care including assessments, care plans and evaluations. Risk assessment tools and monitoring forms are available and implemented. Residents and family interviewed confirmed that they were happy with the care provided and the communication.

Planned activities are appropriate to the resident's assessed needs and abilities and residents advised satisfaction with the integrated activities programme. There are outings into the community and visiting entertainers.

There is a secure electronic medication system at the facility. There are medicine management policies that align with acceptable guidelines. Staff responsible for the administration of medications complete annual medication competencies and education. The general practitioner reviews the medication charts three monthly.

Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on site. The kitchen is well equipped for the size of the service. 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

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Chemicals are stored safely throughout the facility. Appropriate policies are available along with product safety charts. The building holds a current warrant of fitness. Resident rooms are spacious with an adequate number of shower and toilet facilities for the number of residents. There is wheelchair access to all areas. External areas are safe and well maintained. Fixtures, fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are well monitored through the internal auditing system. There is an emergency plan in place including fire safety and there are sufficient civil defence supplies in the event of a civil emergency.

Restraint minimisation and safe practice

<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>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort. There were three residents with restraint and one resident using an enabler on the day of audit. Consents, assessments and evaluations had been completed as per policy. Restraint minimisation, enabler use, and challenging behaviour training is included in the training programme.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection control programme is appropriate for the size and complexity of the service. The infection control coordinator (care centre manager) 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. There have been no outbreaks.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	43	0	2	5	0	0
Criteria	0	93	0	3	5	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<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 nine care staff (four caregivers, two registered nurses (RN), one enrolled nurse, one clinical coordinator and one diversional therapist) confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Four residents (two hospital and two rest home) and five relatives (three hospital and two rest home) were interviewed and confirmed the services being provided are in line with the Code. All staff complete training 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</p>	FA	<p>The service has in place a policy for informed consent and resuscitation. Completed resuscitation treatment plan forms were evident on all seven resident files reviewed (three hospital, including one resident under the young person with disability, and four rest home, including one respite care resident). There was evidence that the general practitioner (GP) completed and signed clinically not indicated resuscitation status where residents were not deemed to be competent. Family discussions were evident in the whānau contact form and progress notes. General consent forms were evident on files reviewed. Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for personal care, entering rooms and so on. Signed admission agreements, enduring power of attorney and activation documentation was evident in the seven resident files</p>

to make informed choices and give informed consent.		reviewed.
<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 Rights 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. An advocate attends the resident three-monthly meetings which is also open to families to attend. Meeting minutes are displayed on the resident noticeboard. The service provides 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. Interview 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 including involvement from the care centre manager for clinical concerns/complaints. There is a complaint register that included relevant information regarding the complaint. Documentation included acknowledgement, investigation, follow-up letters (offering advocacy) and resolution. There was one complaint received in 2018 and three complaints received to date for 2019. 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 and there is a suggestion box available.
<p>Standard 1.1.2: Consumer Rights</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

<p>During Service Delivery</p> <p>Consumers are informed of their rights.</p>		<p>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 the care centre. Three monthly resident advocate meetings and the annual residents/relatives survey is completed and provides an opportunity to raise concerns.</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>	<p>FA</p>	<p>Staff interviewed were able to describe the procedures for maintaining confidentiality of resident records, resident's privacy and dignity. 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 (last in June 2019 with 45 attendees).</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>	<p>FA</p>	<p>Summerset has a Māori health plan 2019 – 2020 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 iwi kaumātua and marae (Ngai Te Rangi). The service has access to advisors at the Māori health unit at the DHB and access to cultural education courses. There were residents on the day of audit. Staff interviewed were able to describe how they would ensure they meet the cultural needs of residents identifying as Māori. Treaty of Waitangi and cultural safety is included in the education planner.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture,</p>	<p>FA</p>	<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</p>

<p>Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>account 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. House rules and a code of conduct are included in the employment contract and staff sign a professional boundaries policy on employment. The staff and clinical 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 and clinical nurse leader confirmed an awareness of professional boundaries. 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>	FA	<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 are supported by the village manager and care centre manager.</p> <p>All Somerset 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). There is good liaison and working relationship with the DHB personnel and outside organisations such as the Dementia Foundation. Services are provided at Somerset that adheres to the Health & Disability services standards. There are implemented competencies for caregivers and registered nurses specific to their roles.</p>
<p>Standard 1.1.9: Communication</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</p>

<p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>health status and incidents/accidents as evidenced in 16 accident/incidents reviewed on the electronic register. Resident/relative meetings are held three monthly with an independent advocate. The village manager and the care centre manager have an open-door policy.</p> <p>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 DHB 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>The service provides care for up to 49 residents at hospital and rest home level care in the care centre and up to 20 rest home level of care residents in serviced apartments. On the day of the audit, there were 38 residents in the care centre with 21 at rest home level (including two private paying respite care residents) and 17 hospital level residents including one younger person under 65 years of age. All beds in the care centre are dual-purpose beds. There were no 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 by the Sea has a site-specific business plan and goals that are developed in consultation with the village manager, care centre manager and regional quality manager. The Summerset by the Sea 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 education, integrated village activities and a focus on providing a dementia friendly service.</p> <p>The village manager (non-clinical) has been in the role for almost three years and has a background in human resources. The village manager attends ARC meetings and villager manager meetings and related education sessions. The village manager is supported by a care centre manager/RN.</p> <p>A care centre manager was transferred from another Summerset site in April 2019 and has been in clinical and management roles (roving care centre manager) within Summerset for the last 11 years. The care centre manager has completed a site induction and is working through a role specific orientation. There are weekly meetings with the regional quality manager who was present during the audit. The care centre manager has completed a certificate in wound care and is a Careerforce assessor. The care centre manager is supported by a clinical nurse leader (CNL) who was appointed in May 2019. The CNL has returned to NZ after working in district nursing and dementia care in Australia and has completed an orientation including related competencies.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation</p>	<p>FA</p>	<p>During a temporary absence the office administrator or a roving village manager will cover the village manager's role. The CNL will cover the care centre managers leave. The regional quality manager provides oversight and support. The care centre manager and CNL alternate weeks on-call and the village manager is available on-call for</p>

<p>ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>		<p>facility matters. 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>	<p>FA</p>	<p>Summerset by the Sea is implementing an organisational 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 meetings, 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. Quality data such as infections, accidents/incident, hazards, restraint, audit outcomes, concerns/complaints are discussed and documented in meeting minutes. Meeting minutes and quality data reports and graphs are available to all staff.</p> <p>An annual residents/relatives survey has been completed for 2018 and reports 98% overall satisfaction rate. The results have been communicated to residents.</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. Corrective action plans and re-audits are completed if audit results are less than expected. 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. Infection control is also included as part of benchmarking across the organisation. Data is analysed 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. The service has a health and safety officer (interviewed) who is the property assistant, with health and safety level 1 qualifications. The health and safety committee review</p>

		<p>incidents/accidents/hazards and near misses and provide a report to the quality improvement meeting. Staff interviewed confirmed they are informed when health and safety meetings are due and have the opportunity to provide input into health and safety. 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.</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 June 2019 were reviewed including four unwitnessed falls (link 1.3.6.1), witnessed falls, skin tears and one challenging behaviour incident. 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.</p> <p>Discussions with the village manager, care centre manager and regional quality manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Two section 31 notifications have been lodged with the MOH and DHB November 2018 for unaccounted restricted medications. A full investigation was completed and signed off by the DHB. 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>	PA Low	<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, one RN, one enrolled nurse, two caregivers, one diversional therapist and one health and safety officer/property assistant) were reviewed and all had relevant documentation relating to employment. Not all 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 is a Careerforce assessor. 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. There are good attendance numbers and staff who do not attend are required to read the education material and sign the reading sheet. The training programme is flexible enough to add additional in-services relevant to the service. The service has an educational goal around providing palliative care training. Monthly "zoom" meetings for RNs have commenced with the training educator at head office. External</p>

		<p>education is also provided, and RNs are linked to the PDRP (professional development recognition programme) at the DHB. The care centre manager has achieved level four of the PDRP. There are six RNs and a casual RN and care centre manager have completed interRAI training. There are three RNs currently progressing through their terrain training.</p> <p>A competency programme is in place with different requirements according to work type (e.g., caregivers, registered nurse and kitchen). Core competencies are completed, and a record of completion is maintained on staff files and online. The contracted physiotherapist completes safe manual handling and hoist training for staff.</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, care centre manager and clinical nurse leader work 40 hours per week (Monday to Friday) and are available on call for any emergency issues or clinical support. The service provides a 24-hour RN. There is an enrolled nurse on morning shift seven days a week who is allocated to provide packages of care for serviced apartment clients in the morning and completes duties in the care centre for the remainder of the morning shift.</p> <p>There are five caregivers on full morning shifts and four caregivers on the afternoon (three full shift and two short shift) and two caregivers on the night shift. One caregiver with a first aid certificate is allocated to attend emergency calls in the village on each shift.</p> <p>There is a recreational therapist Tuesday to Saturday.</p> <p>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 electronic 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 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>FA</p>	<p>The service has comprehensive admission policies and procedures in place to safely guide service provision and entry to services. Referring agencies establish the appropriate level of care required prior to admission of a resident. The service has a well-developed information pack available for residents/families/whānau at entry outlining services able to be provided, the admission process and entry to the service. Information gathered at admission is retained in resident's records. All seven admission agreements viewed were signed. Exclusions from the service are included in the admission agreement. Residents and relatives interviewed stated they were well informed upon admission and had the opportunity to discuss the admission agreement with the 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>Planned exits, discharges or transfers are coordinated in collaboration with the resident and family to ensure continuity of care. There are documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. Copies of documentation and handover is kept on file.</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>PA Moderate</p>	<p>There are medicine management policies and procedures that align with recognised standards and guidelines for safe medicine management practice. The RNs, enrolled nurse and senior caregivers are responsible for the administration of medications and have completed medication competencies and annual medication education. The RNs have completed syringe driver training. All medications and robotic rolls were evidenced to be checked on delivery with any discrepancies fed back to the supplying pharmacy. Standing orders are not used by the service. There were three self-medicating residents (one hospital and two rest home) on the day of the audit. One resident did not have a current reviewed competency assessment completed.</p> <p>All medications were stored securely in the locked medication room. Original labels were present on medication in the medication trolley and cupboards. Eyedrops had open dates documented. The medication fridge temperature was not monitored and recorded regularly.</p> <p>Fourteen resident medication charts (six hospital and eight rest home) were reviewed on the electronic medication system. All electronic charts had a photo ID and allergy status documented. The 'as required' medications had an indication for use, however, not all medication charts reflected the effectiveness of 'as required' medication</p>

		administered.
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>Food services is contracted for the provision of meals on site and to the village café. All meals at the service are prepared and cooked on site in a well-equipped kitchen. The head cook oversees the overall management of the kitchen and ordering of supplies. The head cook works from Monday to Friday and the weekends are covered by a casual cook. The cook is supported by two kitchenhands, one of which covers the village café. All kitchen staff are trained in safe food handling and receive ongoing training. The food control plan was verified until 28 June 2019 and the FCP was in the process of being verified again.</p> <p>There is an 8-week seasonal menu that had been reviewed by the contracted dietitian. Menus are adjusted to meet resident preferences, likes and dislikes and alternate meal options are catered for. Texture modified meals, protein drinks, diabetic desserts and gluten free meals are provided, as evidenced on the main kitchen noticeboard and residents' dietary forms. On admission, the registered nurse completes a dietary profile and a copy is given to the kitchen. The RN updates the profiles with any dietary requirements and notifies the kitchen staff as verified by the head cook interviewed. Cooked meals in bain maries are transported in hot boxes to the dining areas in the care centre and ground floor service apartments. Staff were observed serving and assisting residents with their lunchtime meals and drinks. Specialised crockery and utensils are provided as required.</p> <p>The service records all fridge and freezer, cooking, cooling and reheating temperatures daily. End-cooked food temperatures are recorded on all meats and menu foods. All food was stored correctly and dated. 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>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</p>	FA	<p>The service records the reason for declining service entry to potential residents should this occurs and communicates this decision to the potential residents/family/whānau and the referring agency. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency for appropriate placement and advice.</p>

appropriate.		
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>All seven resident files sampled evidenced that residents are admitted with a care needs level assessment completed by the Needs Assessment and Service Coordination (NASC) team prior to admission. Files sampled indicated that personal needs information is gathered during admission from discharge summaries, medical notes, home care assessments and from discussions with the resident and their relative where appropriate. The interRAI assessment tool was utilised as part of the six-monthly care plan updates (link 1.3.3 3). Additional risk assessments for skin integrity, continence and pain, etc, are completed on admission and reviewed six monthly or when there is a change in a resident's condition.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	PA Moderate	<p>Six of the seven (one was a respite admission) resident long-term care plans were reviewed. The long-term care plans, completed within three weeks, records the resident's problem/need and objectives; however, not all had sufficient interventions that reflected the residents' current needs. Residents and families interviewed confirmed their involvement in the care planning process. The resident and family members sign the long-term care plan acknowledgement document as sighted in the resident files. Short-term care plans were evident in use for short-term needs including (but not limited to): wounds, infections and skin conditions and changes in health status. These were reviewed regularly and signed off as resolved or if an ongoing problem, added to the care plan. Resident files demonstrated service integration and evidence of allied health care professionals involved in the care of the resident such as referral to mental health team and physiotherapist.</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>	PA Low	<p>When a resident's condition alters, the registered nurse initiates a review and if required a GP or nurse specialist consultation. Evidence is present of family members being notified of any changes to their relative's health status, incidents and updates. Discussions with families and notifications were documented on the family/whānau contact sheet in the resident files. Interviews with residents and family confirmed that their relative's needs are met, and they are kept informed of any health changes.</p> <p>Adequate dressing supplies were sighted in the treatment room. The wound care file was reviewed. Wound assessments, treatment and evaluations were in place for all current wounds (14 wounds were being treated including skin tears and one leg wound). There were no pressure injuries on the day of audit. The RNs interviewed were able to describe the referral process for a wound care nurse specialist if required. Short-term care plans are used for short-term needs and were sighted for wounds, skin tear and skin infection. Staff interviewed were aware of residents' needs and understood interventions on how to meet them.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. Staff interviewed stated that they have enough stock available and are aware of</p>

		<p>how to access stock if need arises. Sufficient gloves and aprons were available and sighted for staff to utilise.</p> <p>Monitoring forms are available to monitor resident health and progress against implemented interventions. There was a shortfall around neurological observations following falls and frequency of indwelling urinary catheter changes as prescribed. There were no documented interventions for two residents with identified weight loss.</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 service employs a recreational therapist who has commenced diversional therapist (DT) training. She is employed for 30 hours a week working from Tuesday to Saturday, with assistance from caregivers and volunteers on the other days. The lead DT for Summerset group oversees the activity plans and programmes. The activities programme is implemented from Tuesday to Saturday by the recreational therapist, with the Sunday and Monday programme consisting of a morning church service, knitting group and movies in the afternoon.</p> <p>The programme is planned monthly and residents receive a copy of planned monthly activities in their rooms. Monthly and daily activities plans were displayed on noticeboards around the facility. The integrated rest home/hospital programme includes activities of interest or suggestions made by residents. Activities meet the recreational needs of the residents ensuring all residents have the opportunity to attend activities such as exercises, newspaper reading, arts and crafts, board games, quizzes and reminiscing sessions. Special events such as birthdays, Chinese New Year and Easter are celebrated. One-on-one time is spent with residents who choose to stay in rooms or are unable to participate in group activities. There are regular two weekly trips for outings, shopping, and attending community groups/functions including concerts and events. Community visitors include entertainers, village volunteers, guest speakers, school children and pet therapy. Families are invited and welcomed to become involved in the activity programme. The Tuesday knitting group is led by a volunteer team from the village. The younger person activities plan reflected their individual interests and hobbies including bowls and watching movies. Residents are encouraged to maintain their former community links. During the audit, residents and family were observed in activities. The activities and garden team have set up a sensory garden equipped with colourful outdoor seating for residents and families to enjoy.</p> <p>Resident meetings and annual surveys provide an opportunity for residents to feedback on the programme, as well as resident verbal feedback. Residents and family interviewed expressed satisfaction with the activities programme. The recreational therapist is involved in the multidisciplinary review which includes the review of the resident activity plan.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are</p>	FA	<p>There is evidence of resident and family involvement in the evaluation of resident care plans. Initial care plans and long-term care plans were evaluated by the registered nurses. Written evaluations had been completed six monthly or earlier for resident health changes in five of the six long-term resident files reviewed (link 1.3.3.3). There is evidence of multidisciplinary (MDT) team involvement in the reviews including input from the GP, clinical nurse leader, registered nurse, care staff and any allied health professionals involved in the resident's care. Families are</p>

<p>evaluated in a comprehensive and timely manner.</p>		<p>invited to attend the MDT review and asked for input if they are unable to attend. Short-term care plans sighted have been evaluated by the RN as sighted in the resident's files.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Referral to other health and disability services is evident in the resident files sampled. Mental health services, acute local hospital and physiotherapy are some of the allied services accessed by resident referrals in consultation with GP. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Residents/EPOAs are informed and involved in the referral process.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>There are clear policies in place to guide staff in chemical safety and waste management. Management of waste and hazardous substances is covered during orientation and staff have attended chemical safety training. Chemicals sighted were clearly labelled with manufacturer's labels and stored safely throughout the facility. Safety data sheets and product sheets are available. Sharps containers are available and meet the hazardous substances regulations for containers. A hazard register identifies hazardous substances and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff.</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>FA</p>	<p>The building holds a current warrant of fitness that expires in April 2020.</p> <p>There is a maintenance person employed for 37 hours a week, working from Monday to Friday and available on call, after hours and on weekends. The Summerset planned maintenance programme is in place to address reactive and preventative maintenance. All medical and electrical equipment has been tested and tagged. Chair scales are available and have been calibrated and tagged. Call bell checks are completed monthly and recorded, faults detected have been addressed and the actions recorded. Equipment that is not in use have designated storage areas that are located in areas for easy access to staff. Hot water temperatures in resident areas have been regularly monitored and recorded. Water temperature checks were noted between 43-45 degrees Celsius.</p> <p>Hallways are very wide and have safety rails and promote safe mobility while using mobility aids. The facility has enough space for residents to mobilise using mobility aids and residents are observed moving around freely. The external areas and gardens are well maintained. Residents have access to designated external areas that have seating and shade. Staff stated they have sufficient equipment to safely deliver care to meet resident needs.</p> <p>The service has two vehicles (a car and bus) to provide transport to residents and for staff usage. Both vehicles have current vehicle warrants of fitness and registration documents as evidenced.</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>All resident rooms have large ensuites. Fixtures, fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. There is ample space in all ensuites to accommodate shower chairs and hoists if appropriate. There are eight standard rooms with shared communal toilet/shower facilities (with privacy locks) located closely to the resident rooms. The residents interviewed confirmed their privacy is assured when staff are undertaking personal cares.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p>	<p>FA</p>	<p>All resident rooms are spacious to allow care to be provided and for the safe use of mobility aids. Residents are encouraged to personalise their bedrooms as viewed on the day of audit. Staff interviewed reported that they have more than adequate space to provide care to residents.</p>

<p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>		
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>There are numerous spacious communal areas throughout the facility. Activities as observed on the day of the audit are held in the lounges. The lounges are large enough so there is no impact on other residents who are not involved in activities. The arrangement of seating and space allows both individual and group activities to occur. There were smaller lounges/family rooms, equipped with a kitchenette where residents who prefer quieter activities or family/visitors may sit and make a cup of tea/coffee. The dining rooms are spacious.</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>The service has a comprehensive cleaning and laundry manual to guide staff in the safe and efficient use of laundry and cleaning services. Safety data sheets are available in both the laundry and cleaners' rooms. All chemicals are stored in a locked cupboard. There is appropriate personal protective wear readily available. There are dedicated laundry staff and cleaners on duty seven days a week. All laundry is undertaken on site. The laundry is spacious and well organised and divided into a 'dirty and clean' area. The laundry is located on the ground floor and clean laundry is transported in covered trolleys by lift to the care centre. Kitchen washing is laundered in the care centre by caregivers. All other dirty laundry is sorted into red and blue bags, sent via the chute to the dirty area in the main laundry for washing. The laundry staff member interviewed could describe appropriate systems for managing infectious laundry. The laundry had a confirmed cleaning schedule in place, with areas dates and times evidenced.</p> <p>The cleaners' equipment was attended-to at all times or locked away when not in use. Chemical bottles on the trolley had manufacturer labels. There are sluice rooms for the disposal of soiled water or waste. The sluice rooms and the laundry are locked when not in use. Residents and relatives interviewed reported satisfaction with both the laundry and cleaning services.</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>PA Moderate</p>	<p>There are emergency and civil defence plans (including Tsunami) to guide staff in managing emergencies and disasters. Summerset by the Sea has an approved fire evacuation plan dated 13 September 2015. Fire drills occur six monthly. The village manager is the senior fire warden and provides emergency management including fire safety training for all staff on orientation and ongoing as part of the training plan. There are adequate civil defence supplies including equipment, food and water storage for four litres per person per day. Civil defence supplies are checked regularly. There are barbeques and gas bottles for alternative cooking. A generator is available as required and there is battery backup for call bells and lights. Call bells were evident in residents' rooms, lounge areas and toilets/bathrooms. Staff carry walkie talkies and one staff member with first aid responds to village call outs, however there is not always at least one rostered staff member on night shift with a current first aid cert.</p> <p>The facility is secured at night. The village gates are locked at night with access to the emergency services. There are security cameras at entry and exit points.</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>	<p>FA</p>	<p>Residents are provided with adequate natural light and safe ventilation. Documentation and visual inspection evidenced that the environment is maintained at a safe and comfortable temperature. The residents and family interviewed confirmed temperatures were comfortable.</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</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 who is the care centre manager. She previously held the role at another Summerset facility. The infection control officer has a signed job description. The infection control programme is linked into the quality management system and reviewed annually by the infection control quality manager at head office, in consultation with infection control officers. Goals for 2019 are to reduce infections and increase the uptake of influenza vaccines for 2020. There is a monthly "zoom" meeting with the infection control quality manager and all infection control officers. 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</p>

visitors. This shall be appropriate to the size and scope of the service.		sanitisers are available throughout the facility. There have been no outbreaks.
<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>	FA	<p>The infection control officer has been in the role at Summerset by the Sea for 10 weeks. She has a graduate certificate in infection prevention and control and recently an on-line infection control course. The monthly “zoom” meetings with all Summerset infection control officers includes topical infection control.</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, facility meetings and infection control quality manager at head office.</p> <p>The infection control officer has access to an infection control nurse specialist at the DHB, GPs, laboratory, pharmacy and expertise within the organisation.</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 implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable</p>	FA	<p>Policies and procedures are developed and reviewed at head office. The infection control officer is on the policy review committee. Policies are available to all staff. They are notified of any new/reviewed policies and are required to read and sign for these.</p>

for the type of service provided.		
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control officer is responsible for coordinating and providing 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. Education for 2019 to date includes pandemic planning, outbreak management, hand hygiene, waste management and MRSA.</p> <p>Resident education occurs as part of providing daily cares. Care plans can include ways to assist staff in ensuring this occurs.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>The infection control policy includes a surveillance policy that includes a surveillance procedure, process for detection of infection, infections under surveillance, outbreaks and quality and risk management. Infection events are collected monthly and entered 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. 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 across all services 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 staff room infection control noticeboard.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service has policies and procedures to support of the use of enablers and restraints. The policy meets the intent of the restraint minimisation standards. The care centre manager is the restraint coordinator and has a job description which defines the responsibility of the role. There are three hospital level residents with restraint (bedrails/lap belt) and one hospital resident with an enabler (bedrails) on the day of audit. One resident has two restraints. Voluntary consent and assessment for the resident with an enabler were up to date. The enabler is reviewed as part of the monthly clinical meetings. Risks associated with the use of the enabler has been identified in the care plan and monitoring has not occurred at the documented frequency (link 2.2.2.1). Restraint minimisation, enabler training and challenging behaviour is included in the education planner.</p>
<p>Standard 2.2.1: Restraint approval</p>	FA	<p>The role and responsibility for the restraint coordinator is included in the restraint policy. Registered nurses complete a restraint self-learning package on orientation and ongoing education is included in the education</p>

<p>and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>		<p>planner. Care staff also complete self-learning packages. The restraint committee (care centre manager, clinical nurse leader and an enrolled nurse) approve the use of restraints. The restraint minimisation and enabler policy clearly describe responsibilities for staff.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>The restraint coordinator undertakes restraint assessments in consultation with the RNs, GP and in partnership with the family/whānau. Restraint assessments are based on information in the care plan, resident discussions and on observations of the staff. There is a restraint assessment tool available, which is completed for residents requiring an approved restraint for safety. Assessments reviewed for the three residents on restraint and one resident with an enabler were reviewed and all were completed as required and to the level of detail required for the individual residents. Completed assessments considered those factors listed in 2.2.2.1 (a) - (h), however the risks identified were not documented in the care plans for two residents on restraint and one resident with an enabler (link 2.2.3.2).</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>PA Moderate</p>	<p>The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. Monitoring and observation is included in the restraint policy. There are approved restraints documented in the policy. The restraint coordinator is responsible for ensuring all restraint documentation is completed. The approval process includes ensuring the environment is appropriate and safe. Restraint authorisation is in consultation/partnership with the resident (as appropriate) or whānau/EPOA, GP and the facility restraint coordinator. The risks identified were not documented in the care plans for two residents on restraint and one resident with an enabler (link 2.2.3.4). The frequency of monitoring was documented in the care plans; however, this had not occurred for two residents (one restraint and one enabler).</p>
<p>Standard 2.2.4:</p>	<p>FA</p>	<p>The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations occur three monthly as part of</p>

<p>Evaluation</p> <p>Services evaluate all episodes of restraint.</p>		<p>the ongoing reassessment for the resident on the restraint register, and as part of the care plan and GP review.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>Restraint use in the facility is evaluated in the monthly RN team meeting and annually. The restraint coordinator provides monthly restraint and enabler reports to the regional manager. Policies are reviewed by the policy review group at head office. Internal restraint audits identify any areas for improvement. Restraint is discussed at clinical meetings and at handovers. There have been no incidents relating to restraint use.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	<p>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. There are good attendance numbers and staff who do not attend are required to read the education material and sign the reading sheet. The training programme is flexible enough to add additional in-services relevant to the service. Staff have a three-month review following employment, to monitor progress towards completing their orientation programme and identify any learning opportunities. An annual appraisal is completed thereafter. Eight staff files reviewed identified there were no annual appraisals for three staff.</p>	<p>Annual appraisals had not been completed for three staff (enrolled nurse, caregiver and property assistant).</p>	<p>Ensure performance appraisals are completed annually.</p> <p>180 days</p>

<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA Low</p>	<p>All fourteen of medication charts had been reviewed by the GP three-monthly. There are no standing orders in use. Regular and 'as required' medications were prescribed and administered correctly. Medication charts reviewed did not have documented evidence of the effectiveness of the 'as required' medication that was administered. Medication fridge temperatures were not regularly monitored and recorded as per policy.</p>	<p>(i) Six of the fourteen medication charts did not have documented evidence of the effectiveness of 'as required' medication administered.</p> <p>(ii) Medication fridge temperatures are not regularly monitored and recorded.</p>	<p>(i) Ensure effectiveness of 'as required' medication administered is documented for effectiveness.</p> <p>(ii) Ensure medication fridge temperatures are monitored.</p> <p>90 days</p>
<p>Criterion 1.3.12.5</p> <p>The facilitation of safe self-administration of medicines by consumers where appropriate.</p>	<p>PA Moderate</p>	<p>Three self-medicating rest home residents had been assessed as competent to self-medicate by the RN and GP, however, one competency had not been reviewed.</p>	<p>One self-medicating rest home resident competency had not been reviewed by the RN and GP three monthly.</p>	<p>Ensure self-medication competencies are reviewed three monthly.</p> <p>90 days</p>
<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>	<p>PA Moderate</p>	<p>Six of the seven resident files reviewed had an initial assessment completed within 24 hours of admission. In two of the five long-term files reviewed interRAI assessments and care plans were not developed within 21 days of admission. In one of the resident files reviewed, the interRAI</p>	<p>(i) One rest home resident did not have an initial assessment and care plan completed within</p>	<p>(i) Ensure initial assessments and care plans are completed</p>

		<p>assessments and care plan evaluations were not completed six monthly. Residents were seen by their preferred GPs; however, one resident was not seen within five days of admission and one resident had a four-month period between GP visits.</p>	<p>required timeframes.</p> <p>(ii) Two rest home residents did not have an interRAI assessment and long-term care plan completed within 21 days of admission.</p> <p>(iii) One hospital resident did not have six monthly interRAI assessments and care plan evaluations completed.</p> <p>(iv) One rest home resident did not have a medical assessment by a GP within five days of admission.</p> <p>(v) One hospital resident had a four-month period between GP reviews.</p>	<p>with the required timeframes.</p> <p>(ii) Ensure first interRAI assessments and long-term care plans are completed within 21 days of admission.</p> <p>(iii) Ensure the routine interRAI assessment and care plan evaluations are completed six-monthly for all long-term residents.</p> <p>(iv) Ensure all residents are assessed and admitted by GP within five days of admission.</p> <p>(v) Ensure residents are reviewed by a GP at least three-</p>
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				monthly. 90 days
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA Moderate</p>	<p>Assessments assist in developing care plan interventions. The long-term care plans are developed in consultation with the resident/relative. Long-term care plans were in place for all residents that identified the resident goals and objectives, however three of the six long-term care plans had not been updated to reflect the resident current needs and interventions to safely guide care staff in the delivery of care. The one respite resident file reviewed included assessments and a care plan.</p>	<p>Three of six long-term care plans reviewed did not include interventions and needs/supports for the following;</p> <p>(i) One hospital resident with a PEG tube in place did not have interventions regarding management of the PEG tube site, monitoring for complications including infection.</p> <p>(ii) One rest home resident with challenging behaviours did not have interventions related to management of challenging behaviours, identification of triggers and de-escalation techniques.</p> <p>(iii) One hospital resident with a chronic wound that was noted in the short-term care</p>	<p>(j)-(iv) Ensure care plans include interventions to support the resident's current identified needs and supports.</p> <p>90 days</p>

			<p>plan to be transferred to the long-term care plan, did not have interventions in place regarding management of wound care and optimising wound healing.</p> <p>(iv). Two hospital residents who had weight loss identified did not have interventions in place</p>	
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Low	<p>Monitoring forms are used to monitor residents' health and well-being including blood pressure and pulse, weight, blood sugar levels, behaviour, and food and fluid intake. Short-term care plans are used to document short-term needs and supports. Short-term care plans sighted on the day of audit included skin infection, wounds and skin tear, pressure injury risk. These had been reviewed regularly and signed off when resolved or transferred to the long-term care plan.</p>	<p>(i) Five incidents of residents with unwitnessed falls did not have neurological observations monitored and recorded as per policy.</p> <p>(ii) The prescribed intervention around indwelling catheter tube changes were not implemented for one hospital resident that had an indwelling urinary catheter in place.</p>	<p>(i) Ensure neurological observations are completed as per policy.</p> <p>(iii) Ensure urinary catheter interventions regarding changes of tube are implemented as prescribed and recorded.</p> <p>90 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>	<p>PA Moderate</p>	<p>First aid training including cardiopulmonary resuscitation (CPR) is included in the Summerset training plan. Registered nurses, enrolled nurses and senior caregivers (who attend village callouts) complete first aid training. There is not always at least one rostered staff member on night shift with a current first aid cert</p>	<p>There is not always at least one rostered staff member on night shift with a current first aid cert.</p>	<p>Ensure there is a trained first aider on duty at all times for the care centre.</p> <p>60 days</p>
<p>Criterion 2.2.3.2</p> <p>Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:</p> <p>(a) Only as a last resort to maintain the safety of consumers, service providers or others;</p> <p>(b) Following appropriate planning and preparation;</p> <p>(c) By the most appropriate health professional;</p> <p>(d) When the environment is appropriate and safe for successful initiation;</p> <p>(e) When adequate resources are assembled to ensure safe initiation.</p>	<p>PA Moderate</p>	<p>Assessments had been completed for the three residents with restraints and the one resident with an enabler. The assessments included identifying any risks related to the use of the restraints and enabler, however interventions were not documented in the care plan to mitigate all identified risks. The frequency of monitoring had been documented for restraints and enabler but not always completed as instructed</p>	<p>(i) The care plans for two of three residents on restraint and one resident with an enabler did not include interventions to manage the risks related to the restraint as identified through the assessment process, and (ii) monitoring had not occurred as the required frequency for one resident on restraint and one resident on an enabler</p>	<p>(i)Ensure care plans document interventions to manage the risks related to the restraint, and (ii) ensure monitoring occurs at the frequency documented</p> <p>90 days</p>

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

No data to display

End of the report.