

Summerset Care Limited - Summerset Falls

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 Falls
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 2 December 2019 End date: 3 December 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:	46

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
	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 Falls provides rest home and hospital levels of care for up to 85 residents. During the audit there were 46 residents.

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, interviews with residents, family, management, staff and a general practitioner.

The acting care centre manager is appropriately qualified and experienced and is supported by an acting village manager and registered nursing staff. There are quality systems and processes established. Feedback from the residents and families was very positive about the care and services provided. An induction and in-service training programme are in place to provide staff with appropriate knowledge and skills to deliver care.

There are two areas of continuous improvement awarded around reducing the number of resident falls and maintaining a restraint-free environment.

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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Information about services provided is readily available to residents and families. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is evident on noticeboards. Policies are implemented to support rights such as privacy, dignity, abuse and neglect, culture, values and beliefs, complaints, advocacy and informed consent. Care planning accommodates individual choices of residents and/or their family/whānau. Residents are encouraged to maintain links with the community. Complaints processes are implemented, and complaints and concerns are managed appropriately.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Services are planned and coordinated and are appropriate to the needs of the residents. An acting village manager is responsible for the entire facility and an acting care centre manager is responsible for the day-to-day operations of the care facility. Quality and risk management processes are established. Strategic plans and quality goals are documented for the service. A risk management programme is in place, which includes a risk management plan, incident and accident reporting, and health and safety processes. Adverse, unplanned and untoward events are documented by staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. A staff education and training programme is embedded into practice. Registered nursing cover is provided twenty-four hours a day, seven days a week. There are adequate numbers of staff on duty to ensure residents are safe.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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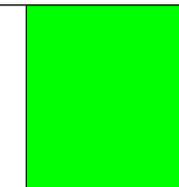
Residents are assessed prior to entry to the service and a baseline assessment is completed upon admission. The registered nurses are responsible for each stage of provision of care including assessments, care plans and evaluations. Risk assessment tools and monitoring forms are available and implemented. 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.

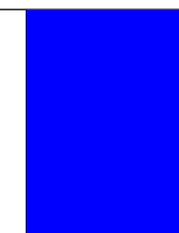
Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on site. The kitchen is well equipped for the size of the service. Food, fluid and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

Safe and appropriate environment

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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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

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		All standards applicable to this service fully attained with some standards exceeded.
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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. Staff receive regular education and training on restraint minimisation. There were no residents using restraints or enablers at the time of the audit.

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.

The infection control programme is appropriate for the size and complexity of the service. The infection control coordinator 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 includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Summerset facilities.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	1	45	0	0	0	0	0
Criteria	2	92	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Code of Health and Disability Consumers' Rights (the Code) brochures are accessible to residents and their families. Policy relating to the Code is implemented and thirteen staff interviewed, including three caregivers (two from the care centre and one from the serviced apartments), two registered nurses (RNs), one administrator, two chefs, one laundry, one cleaner, two recreational therapists, one property services manager/maintenance could describe how the Code is incorporated into their job role and responsibilities. Staff receive training about the Code during their induction to the service, which continues through the ongoing staff education and training programme.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>The service has in place a policy for informed consent and resuscitation. Completed resuscitation plans were evident on the resident files reviewed. 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 providing care and support. Signed admission agreements, enduring power of attorney and activation documentation were evident in the resident files reviewed.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Information on advocacy services through the Health and Disability Commissioner's (HDC) office is included in the resident information pack that is provided to new residents and their family on admission. HDC advocacy brochures are also available at reception. Advocacy contact details are readily available and are provided to complainants in writing. Interviews with residents and family confirmed their understanding of the availability of advocacy services. A consumer advocate from the local community attends resident meetings on a quarterly basis. Staff receive regular education and training on the role of advocacy services, which begins during their induction to the service.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>The service has an open visiting policy. Residents may have visitors of their choice at any time. The service encourages the residents to maintain their relationships with their friends and community groups. Assistance is provided by the care staff to ensure that the residents participate in as much as they can safely and desire to do, evidenced through interviews and observations.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms for lodging informal complaints (feedback) and formal complaints are readily available at the nurse's station and at the entrance to the facility.</p> <p>Information about the complaints process is provided on admission. Family are provided with a copy of the complaints process, which includes links to a range of advocacy services. Interviews with residents and family members confirmed their understanding of the complaints process. Staff interviewed were also able to describe the process around reporting complaints.</p> <p>An electronic complaint register is maintained using VCare. Three complaints were lodged in 2019 (year-to-date). Two of the three complaints have been signed off as resolved. All three (2019) lodged complaints were reviewed. Evidence was sighted to confirm that each complaint had been managed in a timely manner including acknowledgement, and a comprehensive investigation. The complaint that remains open has been referred to the Summerset Regional Manager for input into the actions suggested by family.</p> <p>Complaints received are linked to the quality and risk programme and are communicated to staff, evidenced in meeting minutes. If resolution of the complaint takes longer than 20 days, the complainant is kept informed.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Details relating to the Code and the Health and Disability Advocacy Service are included in the resident information folder that is provided to new residents and their families. An RN discusses aspects of the Code with residents and their family on admission. Discussions relating to the Code are also held during the monthly resident/family meetings. Six residents (three rest home level, which included one resident in the serviced apartments; and three hospital level residents) and four families (three rest home and one hospital) interviewed, reported that the residents' rights were being upheld by the service.</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>The residents' personal belongings are used to decorate their rooms. All rooms are single occupancy in the care facility.</p> <p>The caregivers interviewed reported that they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas. They reported that they promote the residents' independence by encouraging them to be as active as possible. All the residents and families interviewed confirmed that residents' privacy is respected.</p> <p>Guidelines on abuse and neglect are documented in policy. Staff receive annual education and training on abuse and neglect, which begins during their induction to the service.</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>The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. The care staff interviewed reported that they value and encourage active participation and input from the family/whānau in the day-to-day care of the resident. There were no residents living at the facility who identified as Māori during the audit.</p> <p>Māori consultation is available through links with Māori organisations within the community. Staff receive education on cultural awareness. This begins during their induction to the service and continues annually.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe</p>	<p>FA</p>	<p>The service identifies the residents' personal needs and desires from the time of admission. This is achieved in collaboration with the resident, family and/or their representative. The staff demonstrated through interviews and observations that they are committed to ensuring each resident remains a person, even in a state of decline. Beliefs and values are discussed and incorporated into the care plan, evidenced in all seven care plans reviewed. All residents and families interviewed</p>

services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.		confirmed they were involved in developing the resident's plan of care, which included the identification of individual values and beliefs.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	The professional boundaries policy is discussed and signed by each new employee during their induction to the service, evidenced in all eight staff files reviewed. Professional boundaries are also defined in job descriptions. Interviews with staff confirmed their understanding of professional boundaries including the boundaries of the caregivers' role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings, and performance management if there is infringement with the person concerned.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	Evidence-based practice is evident, promoting and encouraging good practice. A registered nurse is available 24 hours a day, seven days a week. A general practitioner (GP) visits the facility a minimum of weekly. Residents are reviewed by a general practitioner (GP) every three months at a minimum. Education and training for staff is provided. A range of competency assessments are completed by staff in addition to in-service training. Reminders are provided to remind staff when competency assessments are due. The caregivers interviewed reported that the education and training sessions are very informative and helpful. Resident/family meetings are held monthly. A consumer advocate leads the meetings four times a year. Residents and families interviewed reported that they are very satisfied with the services received. The last survey (2019) reflected an overall rating of resident satisfaction of 100%. The service receives support from the district health board (DHB) which includes (but is not limited to) specialist visits (eg, mental health services). Physiotherapy services are available one day a week with additional support provided by caregiver staff. A van is available for regular outings. The GP interviewed is satisfied with the care that is being provided by the service.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	An open disclosure policy describes ways that information is provided to residents and families. The admission pack includes a comprehensive range of information regarding the scope of services provided to the resident on entry to the service, and any items they have to pay for that is not covered by the agreement. Regular contact is maintained with families including when an incident or care/health issues arises,

		<p>evidenced in all 13 accident/incident reports that were randomly selected for review. Interviews with families confirmed that they are kept informed.</p> <p>Interpreter services are available if needed. Family and staff are used in the first instance. During the audit there were no residents who were unable to communicate in English.</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>	FA	<p>Summerset Falls provides rest home and hospital levels of care in their care centre for up to 41 residents. All of the rooms in the care centre are certified for dual purpose. There are also 44 serviced apartments certified to provide rest home level care. On the day of the audit, the care centre had 40 residents in the care centre (13 residents at rest home level and 27 residents at hospital level). In addition, six rest home level residents were living in the serviced apartments suitable for rest home level of care.</p> <p>One (rest home level) resident was on respite. The remaining residents were under the aged residential care contract (ARCC).</p> <p>Summerset Falls has a site-specific 2019 business plan. Goals are measurable and include initiatives and action plans. Business goals are regularly reviewed and updated. Progress is reported quarterly to head office.</p> <p>The previous village manager has recently moved to another Summerset facility (one week prior to the audit). She was present during this full certification audit. Her position has been replaced by an acting village manager whilst a suitable replacement is sought. The acting village manager has worked for two years as a relief village manager for Summerset. The acting village manager is supported by an acting care centre manager/registered nurse (RN). The acting care centre manager was previously the clinical nurse lead at this facility (for two years) and has a background in aged care nursing. She has been the acting care centre manager since August 2019. Designated administrative staff are assisting the acting care centre manager while the recruitment process is underway.</p> <p>Village managers and care centre managers attend a two-day Summerset organisational forum each year and maintain over eight hours of professional development relevant to their roles.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is</p>	FA	<p>The office administrator is responsible for the administrative functions of the facility during any absence of the acting village manager or acting care centre manager and the RN's ensure that the acting care centre manager's clinical role is covered in her absence.</p>

<p>managed in an efficient and effective manner which 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>The quality and risk management programmes are established through the Somerset head office. Policies and procedures reflect evidence of regular reviews as per the document control schedule. New and/or revised policies are made available for staff to read and sign that they have read and understand the changes. The acting village manager and acting care centre manager are held accountable for their implementation.</p> <p>Staff, health and safety, and quality improvement meetings are held monthly where quality data is shared with staff. Residents' meetings are also scheduled once a month.</p> <p>The monthly collating of quality and risk data includes (but is not limited to) residents' falls, infection rates, skin tears and pressure areas. Data is collated and analysed to identify trends. Residents/relatives surveys are completed each year. The 2019 survey results indicate that they (along with one other facility) have achieved the highest scores for a Somerset facility with 100% of the respondents indicating that they are satisfied or very satisfied with the services received. These positive results have been shared with residents, families and visitors.</p> <p>A robust internal audit programme monitors compliance on a monthly basis. The audit schedule developed by head office is followed. Corrective actions are developed where opportunities for improvements are identified. Often, the audit is repeated with greater frequency until results reflect acceptable compliance.</p> <p>Falls prevention strategies are being implemented. This includes interventions for all residents as well as specific interventions for residents who are more at risk for falling. The reduction in the number of falls for both rest home and hospital level residents for 2019 has resulted in a rating of continuous improvement.</p> <p>The health and safety programme is overseen by a health and safety officer (acting village manager). He is supported by a health and safety team that meets monthly. A health and safety board is located in the staff room. The head office shares examples of health and safety events. Staff training begins during their induction to the service. A contractor health and safety induction programme is being implemented. Hazard identification forms and a hazard register are being implemented. Each month a health and safety objective is identified with the use of personal protective gear emphasised during the month this audit took place.</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>	<p>FA</p>	<p>The service collects a comprehensive set of data relating to adverse, unplanned and untoward events, which is linked to the quality and risk management system. This includes, (but is not limited to), the collection of adverse event data. Sixteen accident/incident reports were reviewed (thirteen falls, two bruises and one pressure injury). Neurological observations had been completed when there was a suspected injury to the head and for unwitnessed falls. Immediate actions taken are documented on accident/incident reports, which are generated electronically on VCare. Each reported adverse event is reviewed and investigated by an RN (clinical events) and the acting care centre manager. If risks are identified, these are processed as hazards and are reported to the health and safety committee for evaluation at health and safety meetings (sighted).</p> <p>Discussions with the (previous) village manager and acting care centre manager confirmed their awareness of statutory requirements in relation to essential notification. Examples were provided including reporting a norovirus outbreak to the public health authorities and the DHB (August 2018), and one missing resident that required police assistance. The DHB and Ministry were notified regarding the change in care centre management team for the care centre (confirmed by the DHB on 12 November 2019).</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>	<p>FA</p>	<p>There are human resources policies to support recruitment practices. Relevant checks are completed to validate the individual's qualifications, experience and veracity. Reference checks are completed before employment is offered. Job descriptions are in place for all relevant positions that describe staff roles, responsibilities and accountabilities. Eight staff files (one acting care centre manager, two staff RNs, four caregivers, one housekeeper) were reviewed and all had relevant documentation relating to employment in place. Annual performance appraisals had been completed.</p> <p>The service has implemented an orientation programme that provides new staff with relevant information for safe work practices. The orientation programme includes documented competencies and induction checklists. Staff interviewed were able to describe the orientation process and believed new staff were adequately orientated to the service.</p> <p>A list of current practising certificates for health professionals is maintained. There is an annual education plan that is being implemented. Core competencies are completed, and a record of completion is maintained. There is a minimum of one staff available at all times with a current certificate in CPR and first aid. Six out of seven RNs (including the acting care centre manager) are interRAI trained.</p>

<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>Staffing levels and skills mix policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery.</p> <p>The acting village manager and acting care centre manager each work 40 hours per week (Monday to Friday) and are available on call for any emergency issues or clinical support.</p> <p>At the time of the audit, there were 13 rest home level and 27 hospital level residents living in the care centre. Two RNs are rostered in the care centre five days a week on the AM and PM shifts. One RN covers the night shift. One RN is rostered for the AM and PM shifts for the remaining two days. Four long shift and two short shift caregivers cover the AM shift, three long shift and two short shift caregivers cover the PM shift and two caregivers cover the night shift. The acting care centre manager reported that she has not needed to use bureau staff over the past four months with adequate numbers of casual staff to fill unexpected gaps in staffing.</p> <p>There are 44 beds approved for rest home level of care in the serviced apartments. This is broken down into two service areas (main block and block B). One rest home level resident was living in the main block and five rest home level residents were living in block B. Staffing levels in the serviced apartments includes one RN on the AM and PM shifts for two days a week. Two caregivers are rostered on the AM shift (one for the main block and one for block B) and one caregiver is rostered for the PM and night shifts. An interview with one caregiver who regularly works in the serviced apartments confirmed that they regularly check on the residents and that all of the residents are able to use their call bells (observed during an interview with a resident in a serviced apartment).</p> <p>There are separate cleaning and laundry staff, seven days a week.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The residents' files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into each resident's individual record. An initial support plan is also developed in this time. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files have transitioned to an electronic format using VCare. They are protected from unauthorised access with individual password protection. Archived records are secure in separate locked areas.</p> <p>Residents' files demonstrate service integration. Entries are dated and timed and are linked to the individual caregiver or nurse and include their designation.</p>
<p>Standard 1.3.1: Entry To Services</p>	<p>FA</p>	<p>The service has comprehensive admission policies and procedures in place to safely guide service</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>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>FA</p>	<p>There are medicine management policies and procedures that align with recognised standards and guidelines for safe medicine management practice. The RNs and medication competent 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 pre-packaged medication are checked on delivery. Standing orders are not used by the service. There were no self-medicating residents on the day of the audit. Processes for competency assessment and safe storage were in place in the event that a resident was self-medicating.</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 temperatures in each medication room were monitored and recorded regularly. The temperature in the medication rooms were being monitored.</p> <p>Fourteen resident medication charts 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, resident files included information about the effectiveness of 'as required' medication administered.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids</p>	<p>FA</p>	<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 chef oversees the overall management of the kitchen and ordering of supplies. The head chef is supported by two other chefs and kitchenhands. All kitchen staff are trained in safe food handling and receive ongoing</p>

<p>and nutritional needs are met where this service is a component of service delivery.</p>		<p>training. The food control plan expires 27 February 2020.</p> <p>There is a 12-week seasonal menu that had been reviewed by a 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 regional executive chef interviewed. Meals are cooked, probed and put in the scan box and held at 80 degrees centigrade and then transferred to the bain marie for serving. 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.</p> <p>Resident meetings, one-to-one conversations with residents, a communication book for feedback in the residents dining room and surveys allow 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 appropriate.</p>	<p>FA</p>	<p>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. The reason for declining service entry to potential residents is communicated to the potential residents/family/whānau and the referring agency. Potential residents would be referred to the 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 seven resident files sampled evidenced that residents are admitted with a care needs level assessment completed 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. Additional risk assessments (but not limited to) skin integrity, continence and pain, 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>	FA	<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; and reflects the residents' 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>	FA	<p>When a resident's condition alters, the registered nurse initiates a review and if required a GP consultation. Evidence was sighted of family members being notified of 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. The wound care file was reviewed. Wound assessments, treatment and evaluations were in place for all current wounds (15 wounds were being treated including skin tears, one venous ulcer and one chronic ulcer). There was one stage two, non-facility acquired pressure injury on the day of the 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 included a continence assessment, bowel management, and continence products identified. Staff interviewed stated that they have enough stock available and are aware of how to access stock if need arises. There were gloves and aprons sighted and available for staff to utilise.</p> <p>Monitoring forms are available to monitor resident health and progress against implemented interventions.</p>
<p>Standard 1.3.7: Planned Activities</p>	FA	<p>The service employs two recreational therapists who have commenced diversional therapist (DT)</p>

<p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>training. They are employed to provide activities for residents Monday to Sunday.</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 include exercises, word games, basketball toss, church service, bingo, happy hour and a church service.</p> <p>Special events such as Christmas 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 weekly van trips to the beach, out for ice-creams or driving to reminisce. The activities staff have first aid training.</p> <p>Community visitors include entertainers, school and kindergarten children. Residents are encouraged to maintain their former community links. During the audit, residents and family were observed in activities.</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 evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<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 the long-term resident files reviewed. There is evidence of multidisciplinary (MDT) team involvement in the reviews including input from the GP, care centre manager, registered nurse, care staff and any allied health professionals involved in the resident's care. Families are invited to attend the MDT review and asked for input if they are unable to attend. Short-term care plans sighted have been evaluated by the RN 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</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>

to meet consumer choice/needs.		
<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>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>	FA	<p>The building holds a current warrant of fitness that expires 1 February 2020.</p> <p>There is a property services manager and maintenance team employed 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. Call bell checks are completed monthly and recorded. Hot water temperatures in resident areas have been regularly monitored and recorded and were within the required ranges.</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 were 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 enough equipment to safely deliver care to meet resident needs.</p> <p>The service has a van to provide transport to residents. This vehicle has current vehicle warrant of fitness and registration documents.</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</p>	FA	<p>Most resident rooms had ensuites and four resident rooms shared communal toilet/shower facilities (with privacy locks) located closely to the resident rooms. 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. The care staff interviewed confirmed they work to ensure that resident privacy is maintained.</p>

requirements.		
<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	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. Bedrooms have sufficient space to provide care to residents.
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	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>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<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 staff member interviewed described the process for managing laundry. The laundry had a confirmed cleaning schedule in place, with areas dates and times evidenced.</p> <p>The cleaners' equipment was 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.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during</p>	FA	Emergency and disaster policies and procedures and a civil defence plan are documented for the service. Fire drills occur every six months at a minimum. The orientation programme and annual education and training programme include fire and security training. Staff interviewed confirmed their understanding of emergency procedures. Required fire equipment was sighted on the day of audit. Fire equipment has been checked within required timeframes.

<p>emergency and security situations.</p>		<p>There are adequate supplies readily available on each floor of the facility in the event of a civil defence emergency including food, water, and blankets. A generator and gas barbeques are available.</p> <p>A call bell system is in place. Residents were observed in their rooms with their call bell alarms in close proximity or they were wearing a call bell pendant.</p> <p>There is a minimum of one staff available 24 hours a day, seven days a week with a current first aid/CPR certificate.</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 auditor noted on the day of the audit that 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 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 policy in place, and the responsibility for infection control coordinator is an RN. The infection control coordinator 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 coordinators. 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 coordinators. 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>There have been no outbreaks for 2019.</p> <p>There was a norovirus outbreak reported on 10 August 2018 on a Section 31 form. Eleven residents were affected, with three cases tested as positive. Processes were implemented to restrict the spread, which included isolating affected residents and assigning one staff to the affected residents. Standard precautions with laundry and body waste and the use of personal protective equipment were implemented. The mattresses, curtains and shower curtains in affected rooms were disinfected. Education to care staff and the property team is now ongoing; the topic to be covered</p>

		during the month of the audit was the use of personal protective equipment.
<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 coordinator has been in the role for five years. She has attended infection control courses and seminars in the past five years. The monthly “zoom” meetings with all Somerset infection control coordinators includes infection control educational updates.</p> <p>The infection control committee comprises of a cross section of staff from areas of the service. The infection control committee 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 coordinator has access to the gerontology nurse, wound nurse specialist, 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 for the type of service provided.</p>	FA	<p>Policies and procedures are developed and reviewed at head office. The infection control coordinator is involved with organisational policy review. Policies are available to all staff. They are notified of any new/reviewed policies and are required to read and sign for these.</p>
<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 coordinator is responsible for coordinating and providing education and training to staff. The induction package includes specific training around handwashing competencies and standard precautions. Ongoing training occurs annually as part of the training calendar set at head office. Education for 2019 to date includes pandemic planning, outbreak management, hand hygiene, waste management and MRSA. 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>	<p>FA</p>	<p>The infection control programme 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 coordinator 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 previous years data and this information is available to all Somerset sites and used to identify areas of 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 infection control noticeboard.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Staff interviews, and staff records evidenced guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques. Policies and procedures include definitions of restraint and enabler that are congruent with the definition in NZS 8134.0. The restraint coordinator is the acting care centre manager.</p> <p>This facility has been restraint-free since 2017 resulting in a rating of continuous improvement (link 2.2.5.1).</p> <p>Staff receive mandatory training around restraint minimisation that begins during care staff orientation.</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>CI</p>	<p>This facility has been restraint-free since 2017 resulting in a rating of continuous improvement. All incidents of behaviours that challenge are discussed in meetings. Alternatives are determined to avoid the use of restraint.</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.

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	CI	<p>Quality data is tracked, trended and compared with other Somerset aged care facilities. Falls have reduced significantly over the past year and are below the Somerset benchmark resulting in a rating of continuous</p>	<p>Clinical indicator data is reviewed monthly. Trends in data for 2019 reflect a gradual reduction in falls without injury and falls with injury. This has taken place in a restraint-free environment.</p> <p>Strategies implemented to reduce the number of falls and the number of injuries from falls include low beds, sensor mats, hip protectors, intentional rounding, regular toileting and encouraging residents who are at risk of falling to use their call bell, which is available as a pendant. All residents are encouraged to attend the daily exercise programme that is aimed at reducing residents' falls. Another strategy being implemented is a polypharmacy project that has involved clinical staff, the GP and a clinical pharmacist. All residents who are on more than</p>

		improvement.	<p>five medications or are at risk of falling are reviewed monthly by the project team.</p> <p>Results (falls per 1,000 bed nights) for 2019 reflect less than two falls per month over the past three months for residents in the rest home and serviced apartments. This has gradually reduced from an average of five or higher falls per month per 1,000 bed nights earlier in the year. The frequency of hospital level residents' falls has also reduced with an average of twelve falls per 1000 bed nights in May, eleven in June, eight in July, four in August and less than four in September and October.</p>
<p>Criterion 2.2.5.1</p> <p>Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:</p> <p>(a) The extent of restraint use and any trends;</p> <p>(b) The organisation's progress in reducing restraint;</p> <p>(c) Adverse outcomes;</p> <p>(d) Service provider compliance with policies and procedures;</p> <p>(e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;</p> <p>(f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;</p> <p>(g) Whether changes to policy, procedures, or guidelines are required; and</p> <p>(h) Whether there are additional education or training needs or changes required to existing education.</p>	CI	<p>The restraint coordinator has implemented a number of strategies to be able to remain restraint free since 2017.</p>	<p>The restraint coordinator was interviewed. Her philosophy of remaining restraint free was evident throughout the interview. Strategies implemented to remain restraint free since 2017 include (but are not limited to) regular monitoring of residents who are at risk, regular toileting, implementing low beds and fall out mats for at risk residents, and encouraging residents to partake in the daily exercise programme offered to all residents. The additional use of motion sensors are currently on trial. All staff attend a minimum of annual restraint minimisation training which beings during their induction to the service.</p>

End of the report.