

Summerset Care Limited - Summerset in the Bay

Introduction

This report records the results of a Partial Provisional Audit; 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 in the Bay

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

Dates of audit: Start date: 27 February 2020 End date: 28 February 2020

Proposed changes to current services (if any): Ten serviced apartments were assessed as suitable for rest home level of care. The total number of serviced apartments for rest home level of care will increase from 10 to 20.

Total beds occupied across all premises included in the audit on the first day of the audit: 57



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 in the Bay provides rest home and hospital level care for up to 49 residents in the care centre and up to 10 rest home residents in the serviced apartments. On the day of the audit there were 57 residents. A further 10 serviced apartments were assessed as suitable for rest home level of care.

The service is managed by an experienced village manager who has been in the role five years. She is supported by an experienced care centre manager who has been in the role three years. The residents and relatives interviewed spoke positively about the care and support provided at Summerset in the Bay.

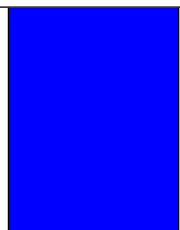
This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, family, management, staff, general practitioner and allied health professionals.

A concurrent partial provisional audit was also conducted to verify the addition of a rest home level care in 10 serviced apartments which are attached to the current facility.

There is an area for improvement around neurological observations.


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

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.		All standards applicable to this service fully attained with some standards exceeded.
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Summerset in the Bay 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.		Standards applicable to this service fully attained.
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Summerset in the Bay has a well-established quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to a number of meetings including monthly quality improvement meetings, infection control and health and safety. 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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There is an admission package available prior to or on entry to the service. Registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family input. Care plans viewed demonstrated service integration and are reviewed at least six monthly. Resident files included medical notes by the contracted general practitioners and visiting allied health professionals.

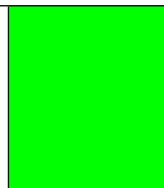
Medication policies reflect legislative requirements and guidelines. Registered nurses and senior caregivers are responsible for the administration of medicines. Medication charts are reviewed three monthly by the GP.

The diversional therapist implements the activity programme to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations.

All meals are cooked on site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. Residents commented positively on the meals.

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.

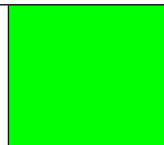


Standards applicable to this service fully attained.

Chemicals are stored safely throughout the facility. Appropriate policies and product safety charts are available. The building holds a current warrant of fitness. The majority of rooms are single and all have ensuites. External areas are safe and well maintained with shade and seating available. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are monitored through the internal auditing system. Systems and supplies are in place for essential, emergency and security services. There is a staff member on duty at all times with a current first aid certificate.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.



Standards applicable to this service fully attained.

Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort. The service has six restraints and three enablers in use. Staff receive regular education and training on restraint minimisation.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.

All standards applicable to this service fully attained with some standards exceeded.

The infection control programme is appropriate for the size and complexity of the service. The infection control coordinator (RN) is responsible for coordinating and providing education and training for staff. The infection control coordinator has attended external training. The infection control manual outlined the scope of the programme and included a comprehensive range of policies and guidelines. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This included audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Somerset facilities. 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	2	47	0	0	1	0	0
Criteria	2	98	0	0	1	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 14 care staff (six registered nurses (RN), seven caregivers including two from the serviced apartments and one diversional therapist (DT) confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Five residents (two hospital, three rest home including one resident in the serviced apartments) and three hospital relatives were interviewed and confirmed the services being provided are in line with the Code. Observation during the audit confirmed this in practice. All staff complete education around consumer rights, last in May 2019.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed</p>	FA	<p>The service has in place a policy for informed consent. Completed general and resuscitation consent forms were evident on all resident files reviewed (three rest home including one in serviced apartments and one short-term respite and five hospital including one ACC and one long-term chronic health care [LTS-CHC]). Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for entering rooms and personal care. Enduring power of attorney (EPOA) evidence is filed in the residents' charts.</p>

consent.		
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	Residents are provided with a copy of the Code of Right and access to advocacy services on entry to the service. Residents interviewed confirmed they are aware of their right to access independent advocacy services and advocacy pamphlets are available at reception. A health and disability advocate visits residents quarterly and a member of Age Concern also visits and is available for discussions with residents as desired. Advocacy contact details are displayed at the care centre resident noticeboard. Meeting minutes and the newsletter are displayed on the resident noticeboard.
<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 cafes. Interview with staff, residents and relatives informed residents are supported and encouraged to remain involved in the community and external groups. There are links with RSA, Age Concern and Dementia Hawkes Bay day care programme. Relative and friends are encouraged to be involved with the service and care.
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	The organisational complaints policy states that the village manager has overall responsibility for ensuring all complaints (verbal or written) are fully documented and investigated. There is an on-line (and hard copy) complaint register that includes relevant information regarding each complaint. There have been two written complaints in 2018 (since the last audit), two complaints (one written and one verbal) for 2019 and one for 2020 to date. The 2020 complaint was received (February 2020) from an Age Concern advocate and is currently being investigated. Documentation for complaints includes acknowledgement, investigation, follow-up letters (offering advocacy) and resolution. Complaints and concerns are discussed at the relevant facility meeting. A complaints procedure is provided to residents within the information pack at entry. Complaint and compliments forms are available for residents/relatives at the care centre reception.
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their 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 resident. Residents and relatives interviewed identified they are well informed about the Code of Rights. The Code of Rights are displayed at the main reception to the care centre. Monthly resident meetings and the annual residents/relatives survey is completed and provides an opportunity to raise concerns.

<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Staff interviewed were able to describe the procedures for maintaining confidentiality of resident records, resident's privacy and dignity. House rules and a code of conduct are signed by staff at commencement of employment. Contact details of spiritual/religious advisors are available. Resident files include cultural and spiritual values and chosen networks and contacts. 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.</p> <p>There is an elder abuse and neglect policy. Staff receive education and training on abuse and neglect, last in May 2019.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>Summerset has a Māori health plan that includes a description of how they achieve the requirements set out in the contract. There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. There were no Māori residents on the day of audit. Links are established with a local kaumātua and the DHB Māori Health Unit.</p> <p>Staff interviewed were able to describe how they can ensure they meet the cultural needs of residents identifying as Māori. Treaty of Waitangi and cultural safety education is provided.</p> <p>Māori staff representative of several iwi in the region reviewed the Summerset Māori Health plan and identified the wording did not accurately reflect the Māori culture of the region. The Māori staff representative of the service included the office manager, three caregivers, one RN and a housekeeper. They consulted with local kaumātua, Māori Health unit at the DHB and ministry of Māori development to develop the draft plan. The RN attended a study day on Māori end of life customs. The final Māori Health Plan for Summerset in the Bay has been accepted by local kaumātua and iwi within the Hawkes Bay. The template has been rolled out in other Summerset sites that enables regions to develop their site-specific plan. The Māori staff developed a Tikanga flip chart as a guide for staff around Māori cultural awareness. The Tikanga flip chart includes an introduction, karakia, whānau support, food, linen and bedpans, taonga valuables, whānau rooms and designated areas, body parts and tissues, pending death and protocols following death. The Tikanga flip chart has been rolled out at other sites.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And</p>	FA	<p>An initial care planning meeting is carried out where the resident and/or family/whānau as appropriate/able are invited to be involved. Individual beliefs or values are further discussed and incorporated into the electronic 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</p>

<p>Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>that staff take into 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>	<p>FA</p>	<p>Staff job descriptions include responsibilities and scope of practice. Staff sign a copy on employment. Staff 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 care centre manager, clinical nurse leader and registered nurses confirmed an awareness of professional boundaries. Caregivers 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>	<p>CI</p>	<p>All Summerset facilities have a master copy of policies which have been developed in line with current accepted best practice and are reviewed regularly. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff. The service has been actively involved in implementing Te Ara Whakapiri – end of life care plans in consultation with the hospice and ARC nurse specialist for palliative care. The service has evidenced good practice around end of life care.</p> <p>There is a culture of ongoing staff development with an in-service programme being implemented. Two senior caregivers have been selected as caregiver coaches who support newly appointed caregivers during the initial orientation and continue to provide ongoing support. Caregivers, once orientation has been completed hold level two Careerforce unit standards. The RNs have the opportunity to attend external education at the DHB. The CNL has attended male catheterisation training at the DHB and has trained and assessed four other RNs to be able to identify any concerns/problems and change/re-catheterise residents as required. The service has eight residents' in-dwelling catheters (link CI 3.5.7). Registered nurses are linked to the DHB professional development recognition programme (PDRP). The service has clinical support and training provided by DHB clinical nurse specialists including wound nurse, ARC palliative care liaison nurse and gerontology nurse specialist. An RN at the facility is the pressure injury prevention champion who has attended training and education to guide and educate staff in pressure injury prevention. The facility aim to reduce pressure injuries by 20% in 2020. The Summerset learning and development team are actively involved in the recruitment and retention of RNs through ongoing support. A quality goal for Summerset in the Bay is to reduce RN turnover by 20%.</p> <p>Residents and relatives interviewed spoke very positively about the care and support provided. Staff have a</p>

		<p>sound understanding of principles of aged care and stated that they feel supported by the village manager, care centre manager and clinical nurse leader.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Residents and family members stated they were welcomed on entry and were given time and explanation about services and procedures. Family members interviewed also stated they are informed of changes in the resident's health status and incidents/accidents as evidenced in 12 accident/incidents reviewed on the electronic register. Resident/relative meetings are held bi-monthly. Meeting minutes evidenced discussion around all areas of services provided. The results of resident/relative surveys have been communicated to residents/relatives. The village manager and the care centre manager have an open-door policy. The service produces a newsletter for residents and relatives.</p> <p>Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so.</p> <p>The service has policies and procedures available for access to interpreter services for residents (and their family/whānau).</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>The service provides care for up to 49 residents at hospital (geriatric and medical) and rest home level care in the care centre. One resident room is designated as a day stay room and one for village residents requiring respite care. There are currently 10 serviced apartments certified for rest home level of care. This audit also included verifying a further 10 serviced apartments suitable for rest home level of care. This would bring the total number of certified serviced apartments to 20.</p> <p>On the day of the audit, there were 46 residents in the care centre with 14 at rest home level (including one respite care) and 32 hospital level (including one resident under long-term chronic health condition and one resident funded by ACC). There were no residents under the Engage contract (Intermediate short-term care with DHB team support engaged in supporting residents to return home). There were 11 rest home residents in the 10 certified serviced apartments including one couple. The DHB have given approval for an additional rest home resident (couple) in the serviced apartments.</p> <p>The Summerset Group Limited Board of Directors have overall financial and governance responsibility and there is a company strategic business plan in place. Summerset in the Bay has a site-specific business plan and quality goals which is linked to the business plan. The 2019 goals have been reviewed and the 2020 goals developed in consultation with the regional operations manager, regional quality manager, village manager and care centre manager. The management team are supported by a regional operations manager and a regional quality manager (present on the days of audit) who visit the facility monthly. There are also regular "zoom" meetings. Summerset in the Bay was awarded village of the Year in 2019.</p>

		<p>The village manager has been in the current role at Summerset in the Bay for five years. The village manager has attended a two-day Summerset Leadership conference and has completed an on-line (21 hours) course "Understanding Dementia" in 2019.</p> <p>The village manager is supported by an experienced care centre manager/RN who has been in the role three years. The care centre manager also attended the Summerset Leadership conference and has attended external education including advance care planning. The care centre manager is supported by a clinical nurse leader (CNL) who has recently attended an aged care conference.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>During a temporary absence, the care centre manager will cover the village manager's role. The regional quality manager provides oversight and support. The CNL provides cover for the care centre manager. The audit confirmed the service has operational management strategies and a quality improvement programme to minimise risk of unwanted events.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>Summerset in the Bay is implementing the organisation's quality and risk management system. There are policies and procedures being implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed on a regular basis from head office. The content of policy and procedures are detailed to allow effective implementation by staff. Staff are required to read and sign for new/reviewed policies.</p> <p>The Summerset group has a 'clinical audit, training and compliance' calendar. The calendar schedules the training and audit requirements for the month. The village manager and care centre manager complete monthly reports confirming completion of requirements. There is a meeting schedule including weekly head of department meetings, monthly quality improvement (all staff) meetings, caregiver meetings and registered nurse meetings. The infection control committee and health and safety committee meet monthly. Quality improvement, health and safety and infection control meeting minutes are available to all staff. Minutes evidence discussion around quality data including infections, accidents/incidents, hazards, audit outcomes, concerns/complaints, medications, wounds and restraint as relevant for the staff group. Trends and analysis for infections and accidents/incidents are displayed on staff noticeboards.</p>

		<p>There are monthly accident/incident benchmarking reports completed by the care centre manager that break down the data collected across the rest home and hospital and staff incidents/accidents. Infection control is also included as part of benchmarking across the organisation. Summerset's clinical and quality manager analyses data collected via the monthly reports and corrective actions are required based on benchmarking outcomes.</p> <p>The service is implementing an internal audit programme that includes environmental, infection control, health and safety, consumer rights and aspects of clinical care. Issues arising from internal audits are developed into corrective action plans and re-audits as required.</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 manager. The village manager is the health and safety officer and has completed a level 3 health and safety course. The health and safety committee comprise of representatives across the services. Three health and safety representatives (interviewed) have completed a level 2 health and safety course and complete health and safety orientation for new employees. The health and safety noticeboard displays the Golden Rule for the month, meeting minutes, risk register and other health and safety information. The service has a return to work programme following staff injury.</p> <p>Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls. Fall prevention strategies are documented in individual care plans and include the use of sensor mats, hip protectors and physiotherapist input.</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>Incident and accident data have been collected and analysed. Twelve resident related incident reports for January 2020 were reviewed including skin tears, pressure injury, challenging behaviour, witnessed and unwitnessed falls. All reports and resident files reviewed evidenced that appropriate clinical care has been provided following an incident, however neurological observations had not been completed following unwitnessed falls (link 1.3.6.1). All incidents/accidents evidenced the relative had been notified. The regional quality manager is alerted automatically through the RMSS system of any high-level accident/incidents (resident, staff and environmental).</p> <p>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 and care centre manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been four Section 31 notifications; one stage three pressure injury (October 2019), two stage four pressure injuries (February 2019 and September 2019) and one deep suspected tissue (December 2019). There have been no outbreaks.</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. A register of practising certificates is maintained for registered nurse, GPs and allied health professionals involved with the service. Eight staff files (one clinical nurse leader, two RNs, three caregivers, one diversional therapist and one cleaner/laundry staff) were reviewed. All files contained the required recruitment and employment documents. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. There are two senior caregiver coaches who support staff through their orientation process. Annual performance appraisals had been completed at three weeks post-employment and annually thereafter.</p> <p>There is an annual education plan that is outlined on the 'clinical audit, training and compliance calendar'. The 2019 training plan has been completed and the 2020 training schedule has commenced. There are two sessions of same raining offered to accommodate staff on all shifts. Records of individual attendance is maintained. A competency programme is in place with different requirements according to work type (eg, caregivers, RN and household staff). Core competencies are completed, and a record of completion is maintained on staff files.</p> <p>Staff have the opportunity to attend external education such as DHB study days and palliative care at the hospice. The physiotherapist provides training and education around use of equipment and safe manual handling. There is a Careerforce assessor at head office.</p> <p>Four of nine RNs have completed interRAI training.</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>The village manager (non-clinical) works full-time (Monday to Friday) and is available on call for any operational issues or non-clinical support. The care centre manager and clinical nurse leader work Monday to Friday and share the on-call. There are two RNs on the morning and afternoon shifts with one RN on night shift.</p> <p>In the care centre there are nine caregivers on morning shifts (four full shifts, four until 1.30 pm and one until 12.30 pm) and two short shifts, six on the afternoon (three full shift and three until 9 pm) and two caregivers on the night shift. One caregiver with a first aid certificate is allocated to attend emergency calls in the village.</p> <p>The serviced apartments are in a separate building and there is a caregiver on duty 24 hours. The care centre RN is allocated to one full day per week to the rest home residents in the serviced apartments. The RN each day visits the serviced apartments at handover. On shifts where there is one RN on duty (afternoons and nights) the on-call RN is contacted.</p> <p>The diversional therapist and recreational therapist cover a seven-day roster for the care centre.</p> <p>There are designated laundry and housekeeping staff for the care centre and serviced apartments.</p> <p>Caregivers interviewed confirmed that staff are replaced. The roster reviewed confirmed that staff are replaced with Summerset staff or agency staff if required. Relatives and residents confirmed there were sufficient staff on</p>

		<p>duty.</p> <p>Partial Provisional</p> <p>The service has employed an RN to be based in the serviced apartments on Monday to Friday morning shifts. The RN in the care centre covers the serviced apartments on weekend mornings, afternoon and nights. On morning shifts, there is a caregiver on full shift and one on short shift (until 1 pm), on afternoon shift there is one caregiver on the full shift and one caregiver on the short shift (finishing at 8.30 pm). There is one caregiver on full night shift. The 10 serviced apartments certified for rest home level of care and the 10 assessed as suitable for rest home level of care are all located on the ground floor. There is a nurses' station for the serviced apartments.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident files were appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Electronic resident files are password protected from unauthorised access. Individual resident files demonstrated 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>	FA	<p>There are policies and procedures to safely guide service provision and entry to services including an admission policy. The service has an information pack available for residents/families at entry. The admission agreements reviewed met the requirements of the ARR contract. Exclusions from the service are included in the admission agreement. All long-term admission agreements sighted were signed and dated. There was a short-term admission agreement for the short-term respite resident.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a</p>	FA	<p>Policy describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. The facility uses the 'yellow envelope' transfer system. Communication with family is made.</p>

planned and coordinated transition, exit, discharge, or transfer from services.		
<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>	FA	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There are currently no residents self-administering. There are no standing orders. There are no vaccines stored on site.</p> <p>The facility uses an electronic and robotic pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. RNs administer all medications. Staff attend annual education and have an annual medication competency completed. All RNs are syringe driver trained by the hospice. The medication fridge and room temperatures are checked weekly. Eye drops are dated once opened.</p> <p>Staff sign for the administration of medications on the electronic system. Sixteen medication charts were reviewed. Medications are reviewed at least three monthly by the GP. There was photo ID and allergy status recorded. 'As required' medications had indications for use charted.</p> <p>Partial Provisional</p> <p>Currently the serviced apartment RN uses the bottom drawer of a care centre medication trolley. However, the nurses' station in the serviced apartments has sufficient space to store a medication and dressing trolley and the nurses' station is able to be locked. The facility has also purchased a lockable safe.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The facility uses a contracted catering service. There is a kitchen manager and two cooks. There are also two kitchenhands. All kitchen staff have current food safety certificates. The kitchen manager oversees the procurement of the food and management of the kitchen. There is a well-equipped kitchen and all meals are cooked on site. Meals are served in the care centre and serviced apartments from hot boxes. The temperature of the food is checked before serving. Special equipment such as lipped plates is available. On the day of audit, meals were observed to be hot and well presented. Residents were offered seconds. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures were monitored and recorded weekly. Food temperatures are checked and these were all within safe limits. The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes were noted. The eight weekly menu cycle is approved by a dietitian. One resident with complicated dietary requirements has these accommodated. The kitchen manager sees the resident weekly and documents a separate personal menu plan. All resident/families interviewed were satisfied with the meals.</p>

		<p>Partial Provisional:</p> <p>There is a dining room in the serviced apartments where the residents can dine. They can also choose to dine in their rooms, in the café and in the care centre dining room.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The service records the reason for declining service entry to potential residents should this occur and communicates this to potential residents/family. 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.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. InterRAI assessments had been completed for all long-term residents whose files were sampled. Overall, the goals were identified through the assessment process and linked to care plan interventions. Other electronic assessment tools in use included (but not limited to) falls risk, pressure injury risk, nutrition and continence.</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>Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans are resident centred. Interventions documented support needs and provide detail to guide care. Short-term care plans are in use for changes in health status. Residents and relatives interviewed stated that they were involved in the care planning process. There was evidence of service integration with documented input from a range of specialist care professionals including the hospice nurse, wound care nurse, gerontology nurse specialist and mental health care team for older people. The care staff interviewed advised that the care plans were easy to follow.</p>
<p>Standard 1.3.6: Service</p>	PA	<p>When a resident's condition changes the RN initiates a GP consultation. Staff stated that they notify family members about any changes in their relative's health status. All care plans reviewed had interventions</p>

<p>Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>Moderate</p>	<p>documented to meet the care needs of the resident and there is documented evidence of care plans being updated as residents' needs changed.</p> <p>Resident falls are reported on the electronic register and in the progress notes. Neurological observations are not always completed when there is a 'knock' to the head or for an unwitnessed fall.</p> <p>Care staff interviewed stated there are adequate clinical supplies and equipment provided including continence and wound care supplies.</p> <p>Electronic wound assessment, wound management and wound evaluation forms are in place for all wounds. Wound monitoring occurs as planned. There is evidence of wound care nurse specialist involvement when required. Photos of wound progress are taken. There are currently nine residents with pressure injuries. Four of these are non-facility acquired. There are three stage two, two stage three and four stage four. All residents are hospital level of care. Two of the residents with pressure injuries are palliative, one is a paraplegic and one has multiple co-morbidities. Section 31s have been documented as required. An RN at the facility is the pressure injury prevention champion who has attended training and education to guide and educate staff in pressure injury prevention. The facility aim to reduce pressure injuries by 20% in 2020.</p> <p>Electronic monitoring forms are in use as applicable such as weight, turning charts, vital signs and wounds. Behaviour charts are available for any residents that exhibit challenging behaviours.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>There is one diversional therapist who works 24 hours a week and one recreational therapist (currently completing the diversional therapy course) who works 30 hours. The DT covers Saturday and there is a student who comes in for two hours on a Sunday. They cover the care centre and the serviced apartments. On the days of audit residents were observed listening to a newspaper reading, doing crosswords and quizzes, doing seated exercises, watching a movie and playing bingo.</p> <p>There is a four-weekly programme in large print on noticeboards in all areas. Every month each resident is given a copy of the programme to keep in their room. Residents have the choice of a variety of activities in which to participate and every effort is made to ensure activities are meaningful and tailored to residents' needs.</p> <p>Those residents who prefer to stay in their room or who need individual attention have one on one visits to check if there is anything they need and to have a chat.</p> <p>Serviced apartment residents are invited daily to join in with the care centre activities and they also have the option of joining in the village activities. The activities staff hold activities in the serviced apartment lounge at least twice a week.</p> <p>There is an interdenominational church service every two months and Catholic communion every week.</p> <p>There are van outings twice weekly. The driver and van assistant both have first aid certificates. Happy hour is</p>

		<p>weekly and there are entertainers three times a month. Celebrations such as birthdays, Valentine's day, Easter, Mothers' day and the Melbourne Cup also occur.</p> <p>There is monthly pet therapy and one resident has goldfish. Families also bring in pets.</p> <p>There is community input from the local pre-schools, choirs and Plunket mums and babies. Recently the Dovetail book club has started – the books are geared to residents with cognitive impairment and have been a great success.</p> <p>Residents go out to the RSA, art and craft groups and meet up with other aged care facilities for afternoon tea and entertainment.</p> <p>Residents have an activity assessment completed over the first few weeks following admission that describes the residents past hobbies and present interests, career and family. Resident files reviewed identified that the comprehensive individual activity plan is based on this assessment. Activity plans are evaluated at least six monthly at the same time as the review of the long-term care plan.</p> <p>Resident meetings are held two monthly.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Except for the short-term respite resident, all care plans reviewed had been evaluated by the registered nurse six monthly or when changes to care occurred. Short-term care plans for short-term needs are evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. Activities plans are in place for each of the residents and these are also evaluated six monthly. The multidisciplinary review involves the RN, GP and resident/family if they wish to attend. There is at least a three-monthly review by the GP. The family members interviewed confirmed that they are informed of any changes to the care plan.</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</p>	FA	<p>Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where residents had been referred to the wound care nurse specialist, mental health services for older people and the hospice nurse. Discussion with the registered nurse identified that the service has access to a wide range of support either through the GP, specialists and allied health services as required.</p>

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 policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas. Safety data sheets and product sheets are available. Sharps containers are available and meet the hazardous substances regulations for containers. The 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 which expires 1 August 2020. There is a property manager who works full time. There is an assistant property manager who also works full time. Both work in the serviced apartments and village as well. There are two gardeners. Contracted plumbers and electricians are available when required.</p> <p>Preventative and reactive maintenance occurs. Electrical equipment has been tested and tagged. The hoist and scales are checked annually. Hot water temperatures have been monitored randomly in the care centre and serviced apartments with rest home level of care residents and were within the acceptable range. The communal lounges, hallways and bedrooms in the care centre and serviced apartments are carpeted. The corridors are wide, have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. There is a lift between the ground and first floor. This is large enough to accommodate beds/stretchers if required. The external areas and gardens were well maintained. All outdoor areas have seating and shade. There is safe access to all communal areas.</p> <p>Caregivers interviewed stated they have adequate equipment to safely deliver care for rest home residents in the care centre and serviced apartments as well as hospital residents.</p> <p>Partial Provisional:</p> <p>The 10 serviced apartments are located on the ground floor in the same area as the existing 10 certified serviced apartments for rest home level of care. The rooms are appropriate for providing rest home level care.</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 but four rooms in the care centre have ensembles. The four rooms without ensembles have hand-basins and there are communal showers and toilets close by. The communal showers are large enough to accommodate shower trollies if required. All serviced apartment rooms have ensembles. Fixtures, fittings and flooring are appropriate. Toilet/shower facilities are easy to clean. There is ample space in toilet and shower areas to accommodate shower chairs and hoists if appropriate (including serviced apartments). There are signs on all communal shower/toilet doors.</p> <p>Partial Provisional:</p> <p>All serviced apartments are one bedroom with an adjoining ensuite with sufficient space to accommodate shower chairs and mobility aids as required.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>All rooms are single. There is sufficient space in all areas to allow care to be provided and for the safe use of mobility equipment. Staff interviewed reported that they have adequate space to provide care to residents. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.</p> <p>Partial Provisional:</p> <p>All 10 serviced apartments are one bedroom. The bedroom is large enough for two king singles or one double bed with sufficient space to deliver rest home level of care for a couple also.</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>In the care centre there are large and small lounges. Activities occur in the larger areas and the smaller areas are spaces where residents who prefer quieter activities or visitors may sit. The dining room is spacious. There is a hairdressing salon on site.</p> <p>Partial Provisional:</p> <p>Each serviced apartment has an open plan kitchenette, dining and lounge room. Communal areas in the serviced apartments include a spacious lounge, seating areas, dining room and a library.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p>	<p>FA</p>	<p>All laundry is done on site. There is a laundry worker who works fulltime. There is also a laundry assistant. The laundry is divided into a "dirty" and "clean" area. There is a laundry and cleaning manual and safety data</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>sheets. Personal protective equipment is available. Cleaning and laundry services are monitored through the internal auditing system. The cleaners' equipment was attended at all times or locked away. All chemicals on the cleaners' trolley were labelled. There is a sluice room in the care centre for the disposal of soiled water or waste and the sluicing of soiled linen. The caregivers from the serviced apartments use the care centre sluice if required. The sluice room and the laundry are kept closed when not in use.</p> <p>Partial Provisional:</p> <p>There is a cleaner's room where the trolley is kept when not in use. There is a designated cleaner for the serviced apartments. There is a small domestic laundry in the ensuite that can be used, however laundry is done in the main laundry for rest home residents in serviced apartments.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>There are emergency and civil defence plans to guide staff in managing emergencies and disasters. Civil defence and emergency planning are included in the education planner and last competed in January 2019. The service has an approved fire evacuation plan and fire drills occur six monthly. There is a designated and trained fire warden on duty at all times.</p> <p>There is civil defence equipment available and includes sufficient food, alternative cooking with three barbeques and sufficient stored tank water. There is an on-site generator that is checked monthly. There is a first aid trained RN and caregiver on duty at all times who responds to village callouts.</p> <p>Call bells were evident in residents' rooms, ensuites, communal toilets, dining and lounge areas. Care staff have pagers which receive all calls (from the care centre and serviced apartments) and walkie talkies for communication on duty. The facility is secured at night with call bell access at the front doors. The village is secure with main gates that are locked after hours with access for village residents and emergency services. There are random night security checks carried out by a contracted security firm.</p> <p>Partial Provisional:</p> <p>Fire evacuation drills occur six monthly with the serviced apartments. There are call bells in the lounge, bedroom and ensuites of the serviced apartments (including the 10 assessed on the day of audit) certified for rest home level of care.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural</p>	<p>FA</p>	<p>All bedrooms and communal areas have ample natural light and ventilation. There is underfloor heating in all areas. Staff and residents interviewed stated that this is effective. There is one outdoor area where residents smoke. All other areas are smoke free. Smokers have been offered smoking cessation programmes.</p> <p>Partial Provisional:</p>

light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.		There is underfloor heating in serviced apartments. Ranch sliders from the apartment lounges open out onto a patio. Opening windows in the bedrooms have security stays in place.
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The infection control programme is appropriate for the size and complexity of the service. There is an infection control responsibility policy that includes responsibilities for the infection control officer. The infection control officer (RN) has been in the role four months with a signed job description. The infection control programme is linked into the quality management system and reviewed annually in consultation with infection control officers. There are monthly “zoom” meetings with all Summerset infection control coordinators. The facility meetings include a discussion of infection control matters including events, trends, analysis and corrective actions.</p> <p>There are notices at main entrances asking visitors not to visit if they are unwell. Influenza vaccines are offered to residents and staff. Hand sanitisers are available throughout the facility. There is adequate personal protective equipment and outbreak kits readily available.</p> <p>There have been no outbreaks.</p> <p>Partial Provisional:</p> <p>The infection control programme includes the serviced apartments.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The infection control coordinator completed an infection prevention and control study day at the DHB in November 2019. There are monthly “zoom” meetings with all Summerset infection control officers which includes topical education. There is an infection control committee with representatives across all services. The committee meets monthly to discuss infection control matters including infection events, trends, analysis and corrective action plans. A report is forwarded to the quality improvement meeting.</p> <p>The infection control team has access to an infection control nurse specialist at the DHB, laboratory, pharmacy, GPs and expertise within the organisation.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the</p>	FA	Policies and procedures are developed and reviewed at head office. Policies are available to all staff. They are notified of any new/reviewed policies and are required to read and sign for these.

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.		
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control coordinator is responsible for coordinating and providing education and training to staff. The induction package includes specific training around handwashing competencies, standard precautions and outbreak management. Ongoing training occurs annually as part of the training calendar set at head office. Registered nurses have access to DHB Ko Awatea on-line learning for infection control. Resident education occurs as part of providing daily cares. Care plans can include ways to assist staff in ensuring this occurs.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	CI	The infection control policy includes a surveillance policy that includes a surveillance procedure, process for detection of infection, infections under surveillance, outbreaks and quality and risk management. Infection events meeting the standard definitions are entered into the electronic system and collated monthly. 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 service has been successful in maintaining urinary tract infections (UTI) below the Summerset average for UTIs for the last year. Infection control audits are completed and corrective actions are signed off (sighted). Surveillance results are used to identify infection control activities and education needs within the facility. Meeting minutes, reports and graphs are displayed on the staffroom infection control noticeboard.
Standard 2.1.1: Restraint minimisation	FA	There are policies around restraints and enablers. The service currently has six hospital residents assessed as requiring the use of restraint (five with bed rails and resident with a bedrail and tabletop tray) and three hospital residents with enablers (bedrails only). Restraint is used as a last resort where alternative strategies have not

Services demonstrate that the use of restraint is actively minimised.		been successful in maintaining resident safety. Residents voluntarily request and consent to enabler use. Staff receive training around restraint minimisation that includes annual competency assessments. The restraint coordinator (RN) oversees restraint minimisation for the service.
Standard 2.2.1: Restraint approval and processes 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.	FA	A restraint approval process and a job description for the restraint coordinator are in place. Discussion around restraint use and approval is on the agenda at the RN monthly meetings. All staff are required to attend restraint minimisation training annually. Care plans include restraint or enabler use and the duration of restraint.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	Restraint assessments are based on information in the resident's care plan, discussions with the resident and family, observations by staff and monitoring of any resident accidents/incidents. A restraint assessment tool meets the requirements (a-h) of the standard. Three hospital level residents' files where restraint was being used (one resident had two restraints) were selected for review. Each file included a restraint assessment and consent form that was signed by the resident's family and GP. The assessment identifies risks associated with the type of restraint applied. Restraint use and risks are linked to the resident's care plan and is regularly reviewed by the restraint coordinator, RNs and GP.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	A restraint register is in place. The register identifies the residents that are using a restraint, and the type(s) of restraint used. The restraint assessment identified that restraint is being used only as a last resort. The restraint assessment and ongoing evaluation of the restraint use process includes reviewing the frequency of monitoring residents while on restraint. Monitoring forms are completed on the electronic system when the restraint is put on and when it is taken off.

<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>Restraint use is reviewed three monthly by the restraint coordinator and the RNs at the monthly RN meeting. The review process includes discussing whether continued use of restraint is indicated and (a) to (k) as listed. The GP reviews restraint use at the three-monthly medical 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>The restraint programme, including reviewing policies and procedures and staff education is evaluated annually by the regional quality manager in consultation with the restraint coordinator. Internal audits monitor compliance of the standard.</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 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA</p> <p>Moderate</p>	<p>When a resident falls it is reported on the electronic register and in the progress notes. Family are notified. Neurological observations are not always completed when there is a 'knock' to the head or for an unwitnessed fall.</p>	<p>Neurological observations had not been completed for four of four unwitnessed falls. Two of four residents had obvious injuries to the head.</p>	<p>Ensure neurological observations are completed for all 'knocks' to the head and unwitnessed falls.</p> <p>60 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, 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 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>The service has worked collaboratively with the ARC hospice nurse and GP to implement the Te Ara Whakapiri to improve the quality of care for residents at the end of life.</p>	<p>In March 2019 the service discussed adopting the Te Ara Whakapiri – “The path to closeness and Unity” for the last days of life. The initiative was discussed with the ARC hospice nurse, management team, GP and RN team. The goal is to provide optimal care to residents in their last days of life and to support their family/whānau as they support their loved one on this journey. Many staff had attended palliative care courses, letters and Master classes provided by Cranford hospice. Nine caregivers completed the introduction to palliative care course and three had completed fundamentals of palliative care. Two RNs had completed fundamentals. The care centre manager, clinical nurse leader and RNs attend monthly palliative care lectures and Master Classes at Cranford hospice. One RN attended end of life customs for Māori. The CNL presented a palliative wound care case review (including the challenges of overcoming pain and malodour) to the Cranford Master class. In June, Hospice provided on-site Te Ara Whakapiri training for all RNs and caregivers. With the training complete, resource folders were set up and Te Ara Whakapiri end of life documentation commenced for residents who were entering the last days of life. The plan of care focuses on the resident’s goals including expectations of care, symptom management and support for the resident and family/whānau. The Cranford Hospice clinical nurse specialist for Aged Residential care was interviewed and stated the use of the tool and care plan enable staff to feel confident in looking after residents who are actively dying. A collaborative team approach ensures that all appropriate care, symptom management and conversations have been had with residents, family/whānau. The GP (interviewed)</p>

			<p>was very positive about the use of the tool and the ease of having all information, assessments, progress notes and goals of care in one document. The GP stated the end of life care for residents is very well done and improves the outcomes, understanding and support for residents and their family/whānau. There have been 12 residents on the Te Ara Whakapiri pathway between August 2019 and February 2020. Letters and cards sighted were very positive and complimentary of the care, the staff and their experience at the end of their loved one's journey.</p>
<p>Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>	CI	<p>Summerset in the Bay have been implementing a project for the reduction of urinary tract infections (UTI) over the last year. The service has a lower UTI average than the overall Summerset UTI average and have been successful in reducing the incidence of UTIs, particularly during the hotter summer months.</p>	<p>The infection control coordinator (RN) (previous and current) developed and implemented a project action plan in consultation with the infection control committee for the reduction of UTIs. The action plan included infection control education around hand hygiene, use of personal protective wear, hydration and continence management. Sessions were repeated and demonstrate 90% of all staff attended. Hand hygiene competencies were completed by all staff. Additional hydration rounds were added to the task list and fluids in other forms were offered such as ice-blocks. Regular toileting regimes continued. Alternative therapies for suspected UTIs included Ural sachets and Hiprex. There were three residents known to be prone to UTIs and the infection control coordinator could identify the spikes in UTIs to these residents. The service has eight residents with indwelling catheters and there have been no UTIs relating to those residents with indwelling catheters. The six-month rolling average for UTIs at Summerset in the Bay of 0.25 – 0.75 per 1,000 bed days have been lower than all Summerset care centres (1.3 – 1.5 UTIs/1000 bed days). There were zero UTIs for January and February 2020.</p>

End of the report.