

# Summerset Care Limited - Summerset Monterey Park

---

## Introduction

This report records the results of a Surveillance 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 BSI Group New Zealand Ltd, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

<b>Legal entity:</b>	Summerset Care Limited
<b>Premises audited:</b>	Summerset Monterey Park
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 9 April 2021      End date: 9 April 2021
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	54

# 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 Monterey Park provides rest home and hospital (geriatric and medical) level care for up to 104 residents. On the day of the audit there were 50 residents in the care centre and 4 rest home level residents residing in the 52 serviced apartments certified for rest home level of care.

The village manager is appropriately qualified and experienced and is supported by an experienced care centre manager and clinical nurse lead/registered nurse. The residents, relatives and nurse practitioner interviewed spoke positively about the care and services provided.

This unannounced surveillance audit was conducted against a subset of 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, relatives, management, staff and the general practitioner.

The service has addressed all three shortfalls from the previous (partial provisional) audit around building compliance, landscaping and the fire evacuation plan.

This surveillance audit identified that there is one improvement required in relation to the complaint process.

## 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.		Some standards applicable to this service partially attained and of low risk.
--	--	---

Residents and relatives are kept up to date when changes occur or when an incident occurs. Systems are in place to ensure residents are provided with appropriate information to assist them to make informed choices and give informed consent.

A complaints policy is documented that aligns with the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). A complaints register is held in an electronic format.

## 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.
---	--	--

Organisational performance is monitored to ensure it aligns with the identified values, scope and strategic direction of the Summerset organisation. The business plan is tailored to reflect goals related specifically to Summerset Monterey Park. There are policies and procedures to provide appropriate support and care to residents. Meetings are held at regular intervals to discuss quality and risk management processes. There is a health and safety management programme that is implemented with evidence that issues are addressed in a timely manner.

An orientation programme is in place and there is ongoing training provided as per the developed training plan. Rosters and interviews indicated that sufficient staff are appropriately skilled, with flexibility of staffing to meet clients' needs. Registered nursing cover is provided twenty-four hours a day, seven days a week.

## 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.
--	--	--

Registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with resident and/or family input. Care plans viewed demonstrated service integration and are reviewed at least six-monthly. Resident files include medical notes by the contracted nurse practitioner and visiting allied health professionals.

Registered nurses and the enrolled nurse are responsible for the administration of medicines. Medication charts are reviewed three-monthly by the nurse practitioner.

The recreational therapists implement 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/family expressed satisfaction with 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.

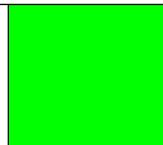


Standards applicable to this service fully attained.

A current code of compliance is posted in a visible location. There are documented processes for the management of waste and hazardous substances. Chemicals were stored safely throughout the facility. An up-to-date fire evacuation plan has been approved by the fire service. Documented systems are in place for essential, emergency and security services. Call bells are in all resident areas. There is always a staff member on duty 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 are in place to guide staff in the use of an approved enabler and/or restraint. On the day of audit there were two residents using restraint and five residents using an enabler. Staff training has been provided around restraint minimisation and management of challenging behaviours.

## 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.

Information obtained through surveillance is used 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. There have been two outbreaks. Both well managed and both reported to the appropriate authorities.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	16	0	1	0	0	0
<b>Criteria</b>	0	45	0	1	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	PA Low	<p>The village manager has overall responsibility for ensuring all complaints (verbal or written) are fully documented and investigated. The care centre manager deals with complaints in the care centre, in consultation with the village manager.</p> <p>A complaints procedure is provided to residents within the information pack at entry. Feedback forms are available for residents/family members in various places around the facility. The complaints register is held in an electronic format. Seven formal complaints were lodged in 2020 and no complaints have been lodged in 2021 (year-to-date).</p> <p>Three complaints reviewed during the audit indicated that they were acknowledged in a timely manner but there was a lack of documented evidence to suggest that these complaints had been investigated and resolved. This is an area for improvement.</p> <p>There have not been any complaints lodged with the Health and Disability Commissioner since the facility opened (20 March 2018). The DHB and managers/staff are regularly involved with one resident and family who have lodged complaints with the facility and with the DHB. Evidence was sighted to suggest that the complainant's ongoing concerns are being managed promptly and effectively (link 1.3.3.3 hospital tracer).</p>
Standard 1.1.9:	FA	Six residents (four hospital level, two rest home level) and four relatives (hospital level) confirmed they were given an explanation about the services and procedures and were orientated to the facility as part of the entry process.

<p>Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>Relatives stated they are regularly kept informed of changes in their family member's (resident's) health status and if any incidents/accidents occur. A review of ten incident forms confirmed that family were informed.</p> <p>Resident meetings take place every month. Family meetings are scheduled three-monthly. Residents and family interviewed confirmed that the village manager, care centre manager and the clinical lead/registered nurse (RN) are very approachable and have an open-door policy.</p> <p>Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The service has policies and procedures available for access to interpreter services for residents (and their family). If residents or family/whānau have difficulty with written or spoken English, the interpreter services are made available through the district health board. There are staff on site who speak a range of languages.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Summerset at Monterey Park is a retirement village that includes a care centre with 52 beds suitable for rest home or hospital level of care. In addition, 52 serviced apartments, located on two floors, are certified for rest home level of care. On the day of the audit there were 50 residents in the care centre (22 rest home and 28 hospital) and four rest home level residents in the serviced apartments. One rest home level resident in a serviced apartment was on respite. All remaining residents were under the age-related residential care contract.</p> <p>Summerset group has a well-established organisational structure. Each of the Summerset facilities throughout New Zealand are supported by this structure. The Summerset group has a comprehensive suite of policies and procedures, which guides staff in the provision of care and services. The Summerset Group Limited Board of Directors have overall financial and governance responsibility and there is a company strategic business plan in place. Summerset at Monterey Park has a site-specific 2021 business plan and goals that are developed in consultation with the village manager, care centre manager and regional quality manager. There is a full evaluation completed at the end of each year with a quarterly review of progress documented against goals throughout the year. Interviews with the managers (village manager, care centre manager) and eleven staff (three caregivers, one enrolled nurse (EN), three registered nurses (RNs), one property manager, one kitchen manager, two recreational therapists) confirmed their involvement with the facility's quality and risk management programmes.</p> <p>The service has a village manager who has been in the role for over one year. Prior to this role, she was the village manager at another Summerset village. She is supported by an experienced care centre manager (RN) who has been in the role since March 2020. Previous to this role she was a Summerset roving manager and has worked with the organisation for over six years. The village manager and care centre manager are supported by a regional quality manager. A clinical nurse lead (CNL)/RN supports the care centre manager in the care centre.</p> <p>The village manager and care centre manager have attended at least eight hours of leadership professional development relevant to their respective roles.</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>There is an established 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. The content of policies and procedures are detailed to allow effective implementation by staff.</p> <p>The Summerset group has implemented a 'quality programme annual calendar' for each of their Summerset locations. The calendar schedules monthly activities (eg, training, meetings, internal audits, and monthly reports). Evidence was sighted to indicate that Summerset at Monterey Park is implementing these activities as per the schedule. Issues arising from internal audits are developed into corrective action plans with evidence of resolution of issues.</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 are compared to other Summerset services of similar size and composition. Infection control is also included as part of benchmarking across the organisation. Data is analysed via the monthly reports and corrective actions are implemented where indicated based on benchmarking outcomes. For example, Summerset at Monterey Park is actively working on reducing the number of residents' falls that are currently above the Summerset benchmark. Quality data is shared with staff via meetings and is displayed in the staffroom, including meeting minutes that detail quality data and results.</p> <p>There is a health and safety plan with evidence of regular reviews at the monthly health and safety meetings. There are health and safety representatives, and two interviewed (property manager, village manager) confirmed their role in escalating any issues and making sure that health and safety issues are addressed. The service addresses health and safety by recording hazards and near misses, sharing of health and safety information and actively encourage staff input and feedback. The service ensures that all new staff and any contractors are inducted to the health and safety programme with a health and safety competency completed by staff as part of orientation.</p> <p>Falls prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. A physiotherapist assesses all new residents and any resident who has experienced a fall. Frequent fallers are identified and known to staff. Intentional rounding, sensor mats, regular toileting and hydration, and monitoring the timeliness of responding to call bells are being implemented to help to reduce the number of residents falling.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse,</p>	<p>FA</p>	<p>Incident/accident data is collected and analysed. A review of ten incident/accident forms (two witnessed and seven unwitnessed falls, one skin tear) identified they were all fully completed, including follow-up by a registered nurse and that family had been notified. Post-falls assessments include neurological observations for the unwitnessed falls.</p>

<p>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>The incident reporting policy includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Data is linked to the organisation's benchmarking programme and used for comparative purposes.</p> <p>Discussions with the management team confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Public health authorities were notified for one (gastroenteritis) outbreak and one scabies outbreak. No Section 31 reports have been required since the previous audit.</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. Five staff files reviewed (one housekeeper, two caregivers, one RN, one recreational therapist) were reviewed and all had relevant documentation relating to employment.</p> <p>Evidence of current practising certificate were sighted for the RNs, one enrolled nurse (EN) and the contracted health professionals (eg, physiotherapist, nurse practitioner, podiatrist, dietitian, pharmacy).</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and believed new staff were orientated well to the service. The orientation programme includes a buddy system with the new staff member working alongside an experienced care staff member. Care staff complete competencies as part of orientation relevant to their role.</p> <p>There is an annual education plan that is outlined on the quality programme annual calendar. The 2021 education plan is being implemented. A competency programme is in place with different requirements according to work type (eg, caregivers and RNs). Core competencies are completed, and a record of completion is maintained. Staff interviewed were aware of the requirement to complete competency training and commented that the current education programme was informative and interesting. Five of twelve RNs have completed their interRAI training. Two caregivers hold a level four Careerforce qualification and two hold a level three qualification. The remaining caregivers have a level two qualification.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from</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. There are clear guidelines for increase in staffing depending on the acuity of residents. A staff availability list ensures that staff sickness and vacant shifts are covered, and a review of rosters confirmed that staff are replaced when on leave. Agency is only used as a last resort with the care centre manager reporting that staffing levels have improved significantly over the past three-six months and agency is only used at a minimum.</p> <p>Interviews with residents and relatives confirmed that staffing levels are sufficient to meet the needs of residents.</p>

<p>suitably qualified/skilled and/or experienced service providers.</p>		<p>The village manager and care centre manager both work 40 hours per week from Monday to Friday and are available on call for any emergency issues or clinical support. The CNL works Tuesday – Saturday.</p> <p>Care centre (28 hospital and 22 rest home residents): The AM shift is staffed with two RNs and eight caregivers (four long (7-8 hour) shifts and four short shifts (two 0700 – 1300 and two 0700 – 1100). The PM is staffed with two RNs and seven caregivers (four long and three short - two 1600 – 2130 and one 1700 – 2100). Two RNs are rostered three nights a week and one RN is rostered on the remaining four nights. They are supported by three caregivers. An extra RN is rostered one day a week on the AM and PM shifts to assist with documentation requirements. Bureau staff (caregivers only) are needed for cover approximately once per week.</p> <p>The serviced apartments (spread across two levels with four rest home level residents all located on the ground level) is staffed with one caregiver on duty for the morning, afternoon, and night shifts.</p> <p>Caregivers and RNs interviewed confirmed that there are sufficient staff on duty and that staff are replaced.</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 comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were three residents self-administering medications on the day of audit. All consents and competencies had been signed. The RN checks the resident's medications have been taken daily. There are no standing orders. Residents in the serviced apartments are either self-medicating or the RN administers the medications. The self-medicating residents keep medications locked away.</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. RN's attend annual education and have an annual medication competency completed. The medication room and medication fridge temperatures are checked weekly and were within ranges. Eye drops are dated once opened.</p> <p>Staff sign for the administration of medications electronically. Ten medication charts were reviewed (six hospital and four rest home). Medications are reviewed at least three-monthly by the nurse practitioner. There was photo ID and allergy status recorded. 'As required' medications had indications for use charted.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs</p>	<p>FA</p>	<p>The service has a kitchen manager who works 40 hours weekly and two other chefs who cover the week between them. There are two kitchenhands who work on a rostered system. The café has four staff. The kitchen manager and chefs have current food safety certificates. The kitchenhands and café staff have internal training. The kitchen manager oversees the procurement of the food and management of the kitchen. There is a well-equipped kitchen, and all meals and baking are cooked on site. Meals are served in each area 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. 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</p>

<p>are met where this service is a component of service delivery.</p>		<p>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. One Indian resident has a curry every day. The ten weekly menu cycle is approved by a dietitian. The residents may ask for other options. Residents can provide feedback on meals through residents' meetings and suggestion boxes located in the dining rooms. All resident/families interviewed were satisfied with the meals and this was evidenced in the latest satisfaction survey. Many stated how they enjoy being able to go to the café with their family and friends.</p> <p>The food control plan was verified 10 August 2020.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>When a resident's condition changes the RN initiates an NP consultation. Staff stated that they notify family members about any changes in their relative's health status. All care plans sampled had interventions documented to meet the needs of the resident and there is documented evidence of care plans being updated as residents' needs changed. Electronic short-term care plans are also used for short-term needs.</p> <p>Resident falls are reported on electronic incident forms and written in the electronic progress notes. Neurological observations are taken when the resident hits their 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>Wound assessment, wound management and wound evaluation electronic forms are in place for all wounds. Wound monitoring occurs as planned. There are currently five wounds being managed. There are currently two stage two pressure injuries. These are on the same person. Both are healing.</p> <p>Electronic monitoring forms are in use as applicable such as weight, 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</p>	<p>FA</p>	<p>There are three recreational therapists but only two are currently working on the floor. The other is working in administration and supervising the recreational programme. This person is studying to be a diversional therapist. Of the two therapists on the floor, one works 40 hours a week and the other 28. On the days of audit residents were observed watching a wildlife documentary, going on a van outing, participating in happy hour and playing Trivial Pursuit.</p> <p>There is a weekly activity plan which is displayed in the dining room and reception area. 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. Those residents who prefer to stay in their room or who need individual attention have</p>

<p>needs, age, culture, and the setting of the service.</p>		<p>one on one visits to check if there is anything they need and to have a chat.</p> <p>There is a monthly interdenominational church service and monthly Catholic communion.</p> <p>There are van outings twice weekly. One goes to the local mall for shopping and coffee and the other goes on an outing.</p> <p>Special events like birthdays, Easter, Mothers' Day, Anzac Day and the Melbourne Cup are celebrated. There are monthly entertainers. They have a local group who visit with their pets.</p> <p>One resident runs a poetry group and there is a resident's choir called the 'Hobsonville Swingers'. They go out into the community to perform and have a choir uniform. There is also a garden group who plant and water the boxes on the decks.</p> <p>The facility has developed a strong relationship with the local college. They have run dance classes for the residents and Duke of Edinburgh students come in and assist the recreational therapists. There is also a yoga instructor who comes in and runs classes for the residents. Three residents go out to 'Counterpunch Parkinson's'.</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. The activity assessment is incorporated into the VCare plan and is evaluated at least six-monthly at the same time as the review of the long-term care plan.</p> <p>Resident meetings are held three-monthly.</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>All plans reviewed (except for the respite resident) had been evaluated by the registered nurse six monthly or when changes to care occurred. Care plans had been updated with any changes to health and care. Activities plans (incorporated in the VCare plan) had also been evaluated six-monthly. The multidisciplinary review involves the RN, NP, and resident/family if they wish to attend. There is at least a three-monthly review by the NP. The family members interviewed confirmed that they are informed of any changes to the care plan.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical</p>	<p>FA</p>	<p>The entire building has a current code of compliance which expires on 28 May 2021. This is an improvement since the previous audit. The code of compliance will be replaced by a building warrant of fitness, evidenced during the interview with the property manager.</p> <p>The property manager oversees the maintenance for the care centre and the serviced apartments. There is a reporting system for maintenance requests and repairs, which is entered into the on-line system for approval and sign off when completed. There are essential contractors available 24/7. Monthly work orders are generated that</p>

<p>environment and facilities that are fit for their purpose.</p>		<p>cover planned maintenance (eg, resident equipment checks (wheelchairs, beds, call bells), test and tagging of electrical equipment, laundry and kitchen servicing). Hot water temperatures in resident areas are checked monthly. This is an improvement from the previous audit.</p> <p>Corridors are wide in all areas to allow residents to pass each other safely. There is safe access to all communal areas and outdoor areas are accessible by lift to the first level. Outdoor areas provide seating and shade. The landscaping has been completed. This is an improvement from the previous audit.</p> <p>The caregivers interviewed stated they have all the equipment required to safely provide the care documented in the care plans.</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>Emergency and disaster policies and procedures, a pandemic plan and a civil defence plan are documented for the service. The education and training programme includes fire and security training, which begins during new staff orientation. Staff interviewed confirmed their understanding of emergency procedures. Required fire equipment, sighted on the day of audit in the care centre and serviced apartments, has been checked within required timeframes. A fire evacuation plan that covers the entire facility has been approved by the fire department (29 January 2019). This is an improvement from the previous audit.</p> <p>There are adequate supplies readily available in the event of a civil defence emergency including food, water and blankets. Two gas barbeques are available. There is an emergency generator on site. There is enough stored water, food, and other resources to support all residents in the care centre and those in certified serviced apartments for at least three days in the event of an emergency.</p> <p>A call-bell system is in place. Residents were observed in their rooms with their call-bell alarms in close proximity. 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 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</p>	<p>FA</p>	<p>The surveillance policy describes the purpose and methodology for the surveillance of infections. Definitions of infections are appropriate to the size and complexity of the service. Infections are reported on an electronic register. The infection control coordinator completes a monthly report. Monthly data is reported to the infection control committee, staff meetings and to head office. Meeting minutes are available to staff. The infection prevention and control programme links with the quality programme including internal audits. There is close liaison with the NPs and laboratory service that advise and provide feedback and information to the service. Systems in place are appropriate to the size and complexity of the facility. Benchmarking against other Summerset facilities occur. There was a gastroenteritis outbreak in 2019 and a scabies outbreak in 2020. Both outbreaks were reported to the appropriate authorities. Both outbreaks were well managed. There was a complaint from a relative during the scabies outbreak, but this was to do with communication not the management of the actual outbreak. This has been successfully resolved.</p>

control programme.		<p>During Covid there was no visiting except for palliative care. Family and friends were kept in touch by zoom and emails. Information for staff was in a Covid folder and on all noticeboards. All visitors and contractors are required to complete an electronic health declaration which also serves as contact tracing. Residents and staff are offered annual flu vaccines and will be offered Covid vaccinations when they become available. There is adequate hand sanitisers and signage throughout the facility. There is an outbreak management bin and ample stock of PPE which is checked weekly. There was extra training provided to staff especially around use of PPE, handwashing, and isolation procedures.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. Interviews with the care staff confirmed their understanding of restraint minimisation.</p> <p>At the time of the audit two hospital level residents were assessed as requiring the use of restraint (bed rails) and five hospital level residents were using enablers (lap belts and bed rails). Residents voluntarily request and consent to enabler use. Two resident files using enablers were reviewed and included an assessment and consent for use of an enabler. Staff training has been provided around restraint minimisation and management of challenging behaviours.</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 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p>	PA Low	The electronic complaints register does not consistently include the investigation of the complaint, evidence to indicate that the complainant has been informed of the outcome and evidence to indicate that the complaint is resolved. Two of the three complaints occurred with the previous care centre manager. The third (more recent) complaint was investigated by the current care centre manager. The investigation was uploaded to the complaints register but there was a lack of evidence to indicate that the complaint was resolved.	Three of three complaints reviewed did not indicate that the complaint was resolved, and two of three complaints reviewed did not reflect evidence of an investigation of the complaint.	<p>Ensure the complaints register includes the complaints investigation and communication with the complainant to indicate that the complainant was informed of the outcome and the complaint could be closed.</p> <p>90 days</p>

## Specific results for criterion where a continuous improvement has been recorded

---

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

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

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

No data to display
--------------------

End of the report.