

Summerset Care Limited - Summerset by the Lake

Introduction

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

The audit has been conducted by 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:

Legal entity: Summerset Care Limited

Premises audited: Summerset by the Lake

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 25 May 2021 End date: 26 May 2021

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 7

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

Indicator	Description	Definition
Yellow	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
Red	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Summerset by the Lake provides rest home level care for up to 19 residents including 18 in serviced apartments. On the day of the audit there were seven residents receiving rest home level care.

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 and staff.

The village manager is an experienced registered nurse and manager and is supported by a clinical manager (registered nurse) who oversees the clinical services.

There are quality systems and processes being implemented. An induction and in-service training programme are in place to provide staff with appropriate knowledge and skills to deliver care. The residents and relative interviewed spoke positively about the care and support provided.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Summerset by the Lake provides care in a way that focuses on the individual resident. 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 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 by the Lake has an established quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to a number of meetings including monthly quality improvement meetings. Annual surveys and monthly resident meetings provide residents and families with an opportunity for feedback about the service. Quality performance is reported to staff at meetings and includes discussion about incidents, infections and internal audit results. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care. There is a staffing policy in place.

Continuum of service delivery

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.

The service has assessment processes and resident's needs are assessed prior to entry. There is a well-developed information pack available for residents and families/whānau at entry. Assessments, resident-centred care plans and evaluations were completed by the registered nurses within the required timeframes. Risk assessment tools and monitoring forms were available and implemented. Resident-centred care plans were individualised and reflected the involvement of allied health professionals in the care of the resident.

A recreational therapist coordinates and implements an integrated activity programme. The activities meet the individual recreational needs and preferences of the consumer groups. There are outings into the community and visiting entertainers.

There are medicine management policies in place that meets legislative requirements. Staff responsible for the administration of medications complete annual medication competencies and education. The general practitioner reviews the medication charts three-monthly.

The food service is contracted to an external company. Resident's individual dietary needs were identified and accommodated. Staff have attended food safety and hygiene training.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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There were documented processes for the management of waste and hazardous substances in place and incidents are reported in a timely manner. Chemicals are stored safely throughout the facility. The building has a current warrant of fitness. Resident rooms (all are apartments with the exception of one single room) are spacious and personalised. There are sufficient numbers of communal toilet/showers. There was sufficient space to allow the movement of residents around the facility using mobility aids or lazy boy chairs. The hallways and communal areas were spacious and accessible. The outdoor areas were safe and easily accessible and provide seating and shade. The service has implemented policies and procedures for civil defence and other emergencies and six-monthly fire drills are conducted. Staff maintain a clean and tidy environment. All laundry and linen are completed on site. There is plenty of natural light in all rooms and the environment comfortable with adequate ventilation and heating.

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.
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There are documented policies and procedures around restraint use and use of enablers. There is nil use of restraint and enablers. Staff training around the use of restraint and enablers is provided and staff interviewed understand the philosophy of minimal use.

Infection prevention and control

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

Standards applicable to this service fully attained.

The infection control programme is appropriate for the size and complexity of the service. The infection control officer (clinical manager) is responsible for coordinating and providing education and training for staff. The infection control officer and infection control committee have attended training. The infection control manual outlined the scope of the programme and included a comprehensive range of policies and guidelines. The infection control officer, along with support office, uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This included audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Somerset facilities.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	45	0	0	0	0	0
Criteria	0	93	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Discussions with staff (four caregivers, one registered nurse (CM) and one recreational therapist) confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Three residents receiving rest home level care and one relative were interviewed and confirmed the services being provided are in line with the Code. Observation during the audit confirmed this in practice.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Informed consent processes were discussed with residents and families on admission. Written general and specific consents were evident in the five resident files reviewed. Four caregivers and one registered nurse (CNL) interviewed confirmed consent is obtained when delivering cares. Resuscitation orders had been appropriately signed by the resident and general practitioner. The service acknowledges the resident is for resuscitation in the absence of a signed directive by the resident.</p> <p>Discussion with a family member identified that the service actively involves them in decisions that affect their relative's life. Five long-term admission agreements were sighted and had been signed on admission.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Residents are provided with a copy of the Code 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. Discussions with one relative confirmed the service provided opportunities for the family/enduring power of attorney (EPOA) to be involved in decisions. The resident files include information on residents' family/whānau and chosen social networks.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Residents and the relative 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 (e.g., shopping and attending cafés and restaurants). Interview with staff, residents and relative interviewed informed residents are supported and encouraged to remain involved in the community and external groups. Relative and friends are encouraged to be involved with the service and care. There is an on-site café which residents and relatives enjoy.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The organisational complaints policy states that the village manager has overall responsibility for ensuring all complaints (verbal or written) are fully documented and investigated. There is a complaint register that included relevant information regarding the complaint. The number of complaints received each month is reported monthly to staff via the various meetings. A complaint had been received in July 2020 via the Health and Disability Commissioner which was investigated by H&D and closed with recommendations relating to documentation and education of staff in relation to the same. This had been completed.</p> <p>The Ministry requested follow up against aspects of a complaint that included complaints management, service provider availability, assessment, care planning, service delivery/interventions, planned activities, care plan evaluation, medication management and nutrition, safe food and fluid management. There were no identified issues in respect of this complaint.</p> <p>A further complaint was received in July 2020 relating to the laundering of clothes. The complaint documentation included follow-up letters, investigation and resolution that had been completed within the required timeframes. Corrective actions had been implemented and any changes required were made. A survey of resident satisfaction in December 2020, specific to the area of complaint, resulted in a 91% satisfaction result. A complaints procedure is provided to residents within the information pack at entry. Feedback forms are available for residents/relatives in various places around the facility.</p>
<p>Standard 1.1.2: Consumer</p>	<p>FA</p>	<p>The service provides information to residents that include the Code, complaints and advocacy.</p>

<p>Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>		<p>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 were well informed about the Code of Rights. Quarterly resident meetings provide the opportunity to raise concerns. An annual residents/relatives survey is completed. Advocacy and Code of Rights information is included in the information pack and is available at reception.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	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. Residents and relatives interviewed reported that residents are able to choose to engage in activities and access community resources. There is an elder abuse and neglect policy. Staff education and training on abuse and neglect is undertaken and an advocate from Age Concern visits the facility three monthly to meet with residents.</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 by the Lake 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. At the time of the audit, there were no residents that identified as Māori. Links are established with local iwi. Staff interviewed were able to describe how they can ensure they meet the cultural needs of residents.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>An initial care planning meeting is carried out where the resident and/or whānau as appropriate/able are invited to be involved. Individual beliefs or values are further discussed and incorporated into the care plan. Six-monthly multidisciplinary team meetings occur to assess if needs are being met. Family is invited to attend. Discussion with family/whānau confirmed values and beliefs are considered. Residents interviewed confirmed that staff take into account their culture and values.</p>
<p>Standard 1.1.7: Discrimination</p>	FA	<p>Staff job descriptions include responsibilities and staff sign a copy on employment. The quality</p>

<p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>		<p>improvement meetings occur monthly and include discussions on professional boundaries and concerns as they arise. Management provide guidelines and mentoring for specific situations. Interviews with the village manager, clinical manager and caregivers confirmed an awareness of professional boundaries.</p>
<p>Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Residents and the relative interviewed spoke positively about the care and support provided. Staff have a sound understanding of principles of aged care and stated that they feel supported by the village manager and clinical nurse lead. All Somerset facilities have a master copy of policies which have been developed in line with current accepted best practice and are reviewed regularly. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff.</p> <p>There is a quality improvement programme that includes performance monitoring against clinical indicators and benchmarking against like services within the group is undertaken. There is evidence of education being supported outside of the training plan. Services are provided at Somerset by the Lake that adhere to the Health and Disability Services Standards. There are implemented competencies for caregivers and registered nurses including (but not limited to): insulin administration; medication; wound care; and manual handling.</p>
<p>Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents and a family member stated they were welcomed on entry and were given time and explanation about services and procedures. The family member interviewed also stated they are informed of changes in resident's health status and incidents/accidents and considers it has improved under current management. The village manager talks weekly with residents in a group and resident meetings are held three-monthly. The village manager and the clinical nurse lead have an open-door policy, and this was evident on audit.</p> <p>The service produces a "flyer" (newsletter) for residents and relatives when there are items of news/significance e.g., a recent one focussed on Covid-19. Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The service has policies and procedures available for access to interpreter services for residents (and their family/whānau). If residents or family/whānau have difficulty with written or spoken English, the interpreter services are made available.</p>
<p>Standard 1.2.1: Governance The governing body of the organisation ensures services</p>	<p>FA</p>	<p>The service provides care for up to 19 residents at rest home level care (18 of these are in Occupational Right Agreement apartments within the central building). The 19th room is a single room with ensuite. At the time of the audit, there were seven residents at rest home level on the Age-Related Residential Care</p>

<p>are planned, coordinated, and appropriate to the needs of consumers.</p>		<p>(ARRC) contract. There were no residents on respite.</p> <p>Summerset by the Lake has a site-specific business plan 2021 and goals that are developed in consultation with the village manager, clinical nurse leader and regional operations manager. The Summerset by the Lake quality plan is reviewed regularly throughout the year. There is a full evaluation at the end of the year.</p> <p>The village manager (RN) has been in the position for over 5 years with 18 years' previous experience managing in aged care. The village manager is supported by a clinical nurse leader. The clinical nurse leader has been in the position for one year in total. She returned to the role three months ago after a period off with an injury. She has a background in district health board hospitals and aged care nursing. There is a regional operations manager who is available to support the facility and staff. The village manager has attended at least eight hours of leadership professional development relevant to the role. The clinical nurse leader has undertaken postgraduate studies in palliative care, the Ministry of Health infection control coordinator training and attends monthly zoom education sessions.</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>	<p>FA</p>	<p>During a temporary absence, the clinical nurse leader will cover the village manager's role. The regional operations manager and the regional quality manager provide oversight and support. The audit confirmed the service has operational management strategies and a quality improvement programme to minimise risk of unwanted events.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>Summerset by the Lake has implemented 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. The content of policy and procedures are detailed to allow effective implementation by staff.</p> <p>The Summerset group has a 'clinical audit, training and compliance' calendar. The calendar schedules the training and audit requirements for the month and the village manager completes a 'best practice' sheet confirming completion of requirements. The best practice sheet reports (but not limited to): meetings held; induction/orientation; audits; competencies; and projects. This is forwarded to head office as part of the ongoing monitoring programme. There is a meeting schedule including monthly quality improvement (full facility) meetings, that includes discussion about clinical indicators (e.g., incident trends,</p>

		<p>infection rates). Management meetings are held weekly, health and safety monthly and infection control monthly.</p> <p>The service has an internal audit programme that includes aspects of clinical care. Issues arising from internal audits are developed into corrective action plans. Monthly and annual analysis of results is completed and provided across the organisation. Health and safety internal audits are completed. Accident/incident/clinical data is entered on VCare electronic system which is accessed by national office and analysed. Other data such as occupancy is loaded on the RMNS electronic system. Infection control is also included as part of benchmarking across the organisation. Summerset's regional quality manager analyses data collected via the monthly reports and corrective actions are required based on benchmarking outcomes.</p> <p>There is a health and safety and risk management programme in place including policies to guide practice. The property manager is the health and safety officer (interviewed). There are six internal health and safety audits each year. The number and nature of events show trends. A monthly newsletter/memo is given to staff covering issues.</p> <p>Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Incident and accident (events) data has been collected and analysed. Discussions with the service confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Five resident/clinical related incident reports for January, February and March 2021 were reviewed (three falls, one choking, and one incident of incomplete medication process completion). All reports and corresponding resident files reviewed evidenced that appropriate clinical care has been provided following an incident. 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>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet</p>	<p>FA</p>	<p>There are human resources policies to support recruitment practices. A list of practising certificates is maintained. Seven staff files (one clinical nurse lead, one registered nurse, one property manager/health and safety officer, one activities officer and three caregivers) were reviewed and all had relevant documentation relating to employment. Performance appraisals had been completed annually. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme includes documented competencies and induction checklists.</p>

<p>the requirements of legislation.</p>		<p>Staff interviewed were able to describe the orientation process and believed new staff were adequately orientated to the service. There is an annual education plan that is outlined on the 'clinical audit, training and compliance calendar'. Core competencies are completed, and a record of completion is maintained. Staff interviewed were aware of the requirement to complete competency training. All caregivers except 2 hold level II, level III or level IV qualifications. All staff working pm/night duties hold level IV. The clinical manager (RN) and an RN cover the facility 8 hours per day, seven days per week. Both are interRAI trained.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The village manager and clinical nurse manager work 40 hours per week (Monday to Friday). The village manager is available on call for any operational issues and the clinical nurse manager (CM) and registered nurse share the on-call responsibilities for clinical support. The CM or registered nurse are on duty for eight hours seven days a week. Both the CM and RN are interRAI qualified. Allowing for the delivery of care packages to the village residents, there are two caregiving (or RN) staff available to rest home residents at all times. A staff availability list ensures that staff sickness and vacant shifts are covered. All staff on pm duty have level four qualifications. Caregivers interviewed confirmed that staff are replaced and there is sufficient coverage. Staffing levels and skills mix policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery. Residents and the relative interviewed stated that there was sufficient staff available.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The resident files were appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Electronic resident files are password protected from unauthorised access. Individual resident files demonstrate service integration.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>All residents have a needs assessment completed prior to entry, that identifies the level of care required. The clinical manager screens all potential enquiries to ensure the service can meet the specific needs of the resident.</p> <p>Two residents and one relative stated that they received sufficient information on admission and discussion was held regarding the admission agreement. The admission agreement reviewed aligns with a) - k) of the ARC contract.</p>

<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>There is an exit, discharge and transfer policy that describes guidelines for death, discharge, transfer, documentation and follow-up. All relevant information is documented and communicated to the receiving health provider or service. Follow-up occurs to check that the resident is settled or, in the case of death, communication with the family is made.</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>	FA	<p>There are medicine management policies and procedures that align with recognised standards and guidelines for safe medicine management practice. The CM and caregivers who administer medications (13) have completed annual medication competencies and education. The service uses an electronic charting and administration system and individual robotic medication rolls. All medications were evidenced to have been checked on delivery with any discrepancies fed back to the supplying pharmacy. Standing orders are not used. There is a self-medicating resident's policy and procedure in place. There were two residents partially self-medicating on the day of audit. Competency had been tested. The treatment room and medication fridge temperature is monitored daily. Eye drops are dated on opening.</p> <p>Seven resident medication charts (there was a total of seven rest home assessed residents) on the electronic medication system were reviewed. The charts had photograph identification and allergy status recorded.</p> <p>All seven medication charts reviewed identified that the GP had reviewed the medication chart three-monthly.</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>All meals are provided by an on-site contracted service. There is a four-weekly rotating, summer/winter menu approved by the dietitian (19 May 2021). The menu includes resident preferences. The cook (interviewed) is notified of any changes to resident's dietary requirements. Resident likes/dislikes and preferences are known and accommodated with alternative meal options. Meals are plated and delivered in hot boxes to the dining room for rest home residents. The cook receives a dietary profile for each resident.</p> <p>The fridge, freezer and end-cooked food temperatures are recorded twice daily. All foods are stored correctly, and date labelled. Cleaning schedules are maintained. Chemicals are stored safely within the kitchen. Staff were observed wearing correct personal protective clothing. The chemical provider completes a functional test on the dishwasher monthly.</p> <p>The Food Control Plan expires June 2021. An onsite verification has been undertaken (May 2021) and</p>

		<p>the site is awaiting further verification.</p> <p>Staff working in the kitchen have food handling certificates and chemical safety training.</p> <p>The kitchen manager receives feedback from resident meetings, surveys and welcomes suggestions on the meal service. The last resident survey resulted in 100% satisfaction.</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 reason for declining service entry to residents should this occur, is communicated to the resident or family/whānau and they are referred to the original referral agent for further information.</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>The initial support plan is developed with information from the initial assessment. Clinical risk assessments are completed on admission where applicable and reviewed six-monthly as part of the interRAI assessment. Outcomes of risk assessment tools are used to identify the needs, supports and interventions required to meet resident goals. The interRAI assessment tool has been utilised for all residents and there were clear links to the care plan.</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>Resident-centred care plans describe the individual support and interventions required to meet the resident goals. The care plans reviewed reflect the outcomes of risk assessment tools and link with the interRAI assessment. Care plans demonstrate service integration and include input from allied health practitioners.</p> <p>Short-term care plans are used for changes in health status. These are evaluated regularly and either resolved or if an ongoing problem, added to the long-term care plan. There is documented evidence of resident/family involvement in the care planning process. Residents/relatives interviewed confirmed they participate in the care planning process.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p>	FA	<p>When a resident's condition changes, the CM initiates a review and if required, a GP consultation. The relative interviewed stated their relative's needs are met and they are kept informed of any health changes. There was documented evidence in the resident files of family notification (highlighted in the</p>

<p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>electronic progress notes) of any changes to health including infections, accidents/incidents and medication changes. Residents interviewed stated their needs are being met.</p> <p>Adequate dressing supplies were sighted. There were no wounds or pressure injuries on the day of audit. The CM confirmed there is access to a wound care specialist at Rotorua Hospital and district nurses.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management and continence products identified for day use, night use and other management. Specialist continence advice is available as needed.</p> <p>There are a number of monitoring forms and charts available for use including (but not limited to): pain monitoring; blood pressure; pulse; blood sugar levels; weight; food and fluid intake; and behaviour charts. These were sighted as used where required.</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>The service employs a part-time recreational therapist (RT) for 16 hours per week across four days and there is a volunteer on the fifth day. The RT is 75% through diversional therapy training.</p> <p>The activity programme is flexible and accommodates spontaneous activities. Volunteers are involved in the programme. Activities meet the recreational needs of the rest home residents including quizzes, news reading, bingo, exercises and mini golf. All serviced apartment residents are invited to attend group activities including entertainment (each Thursday) and speakers. There are fortnightly church services. Residents are encouraged to maintain links with the community (a van is on site and residents routinely go out each Friday) and have visits from the local school children.</p> <p>Monthly meetings provide an opportunity for residents to feedback on the programme. Quarterly meetings are held with the Age Concern advocate. Family are invited to these meetings.</p> <p>The RT completes resident activity assessments, activity plans and six-monthly reviews. The RT maintains individual progress notes with entries monthly or more frequently.</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>Residents and relatives are involved in the review of resident centred care plans. Written evaluations were completed six-monthly or earlier for resident health changes in all files reviewed. There is multidisciplinary (MDT) team involvement in the reviews including input from the GP and any allied health professionals involved in the resident's care. Families are invited to attend the MDT review and asked for input if they are unable to attend. The GP completes three-monthly reviews.</p>

<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The service provided examples of where a resident's condition had changed, and the resident was reassessed for a higher level of care.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Safety data sheets were readily accessible for staff. Chemicals were stored safely throughout the facility. Personal protective clothing was available for staff and seen to be worn by staff when carrying out their duties on the day of audit. Relevant staff have completed chemical safety training.</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 has a current building warrant of fitness that expires on 29 December 2021. There is a full-time property manager who oversees the property and gardening team and is available on call for facility matters. The property manager is a health and safety representative for the facility. Planned and reactive maintenance systems are in place and maintenance requests are generated through the Sway (Summerset way) online system. All electrical equipment has been tested and tagged (May 2021). Essential contractors are available 24 hours. Clinical equipment has had functional checks/calibration annually (May 2021). Hot water temperatures have been tested and recorded monthly with readings below 45 degrees Celsius.</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. The external areas are well maintained.</p> <p>The caregivers and CM stated they have all the equipment required to safely provide the care documented in the care plans. A hoist is available if needed for falls.</p>

<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>The serviced apartments and the single bedroom have spacious full ensuites. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. Residents interviewed stated staff respect their privacy when carrying out hygiene cares.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>There is adequate room to safely manoeuvre around the apartment and communal areas with the use of mobility aids. The doors are wide enough for ambulance trolley access. Residents and families are encouraged to personalise their apartments, as viewed on the day of audit.</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>	FA	<p>Communal areas within the facility include an open plan dining area and kitchenette and main lounge that can accommodate rest home residents and where most activities take place. There is a sunroom/private lounge for resident and family use. There are seating alcoves within the facility. The communal areas are easily accessible for residents.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. All linen and personal clothing is laundered on site by the caregivers. The laundry is well equipped, and all machinery has been serviced regularly. There is personal protective equipment available. The laundry has defined clean/dirty areas.</p> <p>Cleaning trolleys sighted were well equipped and are kept in designated locked cupboards when not in use. External (chemical provider) and internal audits monitor the effectiveness of laundry and cleaning processes.</p>

<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>Information and equipment for responding to emergencies is provided. There is an approved evacuation plan. Fire evacuations are held six-monthly, and the last drill was completed in February 2021. There is staff on each shift with first aid training. There is a civil defence and emergency plan in place. The civil defence kit is readily accessible. The facility is well prepared for civil emergencies and has emergency lighting, a store of emergency water and a gas BBQ for alternative cooking along with a three-burner hob for boiling water. There is a generator on site and staff receive training on how to use along with site-specific civil defence training. Emergency food supplies sufficient for five days are kept. There is a store of supplies necessary to manage a pandemic. The call bell system is available in all areas and rings through to pagers carried by staff, plus show at the end of each corridor and above individual doors. There is a three-hour backup for call bells in an emergency. During the tour of the facility, residents were observed to have easy access to the call bells and residents interviewed stated their call bells were answered in a timely manner.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>Visual inspection evidenced that the residents have adequate natural light in the bedrooms and communal rooms, safe ventilation and an environment that is maintained at a safe and comfortable temperature. Underfloor heating can be individually controlled within the resident's apartment.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	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 (clinical manager) has a signed job description. The infection control programme is linked into the quality management system and reviewed annually at head office in consultation with infection control officers. The facility meetings include a discussion on infection control matters. Since 2020 there has been a focus on outbreak management with supplies of personal protective equipment (PPE) increased and additional education on the use of PPE. From February 2021 to date of audit there had been monthly infection control education including covid management, pandemic kits and a talk by the pharmacist on vaccinations. At the time of audit 99% of care residents and 99% of all staff had received their first covid vaccination.</p>
<p>Standard 3.2: Implementing the infection control programme</p>	FA	<p>The infection control officer (CM) is responsible for coordinating and providing education and training to staff. The induction package includes specific training around hand washing competencies and standard</p>

<p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>		<p>precautions. Ongoing training occurs annually as part of the training calendar set at head office. The infection control officer has attended national Summerset group training, has undertaken the Ministry of Health IC coordinator training and has undertaken a postgraduate certificate which included material on infection control. There is an infection control team which meets monthly. The facility has access to the IC Nurse specialist (DHB), laboratory, GPs and expertise within the organisation.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>There are comprehensive infection control policies that are current and reflected the Infection Control Standard SNZ HB 8134:2008, legislation and good practice. These are across the Summerset organisation.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The infection control officer is responsible for coordinating and providing education and training to staff. The induction package includes specific training around hand washing competencies and standard precautions. Ongoing training occurs as part of the training calendar set at head office. Since March 2021 there have been four infection control training sessions plus competencies undertaken. The pharmacist also gave a talk on Covid vaccination to staff and residents this year. At time of audit 99% of staff and 99% of residents have had their first Covid vaccination.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control</p>	<p>FA</p>	<p>The infection control policy includes: a surveillance policy; a surveillance procedure; process for detection of infection; infections under surveillance; outbreaks; and quality and risk management. Infection events are entered onto the Summerset national electronic system. The infection control officer provides infection control data, trends and relevant information to the Infection Control Committee and staff meetings. Committee meeting minutes and graphs are displayed for staff to see.</p> <p>Infection control internal audits are completed, and corrective actions raised for non-compliance. There</p>

programme.		<p>have been no outbreaks since the previous audit. Management is aware of reporting requirements.</p> <p>Areas for improvement are identified, corrective actions developed and followed-up. The facility is benchmarked against other Somerset facilities of similar size and benchmarking results are fed back to the infection control officer and used to identify areas for improvement. Infection control audits are completed, and corrective actions are signed off (sighted). Surveillance results are used to identify infection control activities and education needs within the facility.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There are policies around restraints and enablers. Staff receive mandatory training around restraint minimisation that includes annual competency assessments. Annual restraint competency questionnaires ask staff to differentiate a restraint from an enabler. The restraint coordinator role is delegated to the clinical manager (RN). There is nil restraint or enabler use.</p>

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, 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.