Summerset Care Limited - Summerset by the Park

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 Park
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 3 February 2022 End date: 4 February 2022

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: 58

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 by the Park provides rest home and hospital level care for up to 111 residents including rest home level care in 55 serviced or independent apartments. On the day of the audit there were 58 residents, including eight rest home residents in serviced apartments. The residents and relatives interviewed spoke positively about the care and support provided.

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

The village manager is appropriately qualified and experienced and is supported by two clinical nurse leaders.

This certification audit identified shortfalls around the business plan, neurological observations, and to part of the quality programme.

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.

Staff at Summerset by the Park strive to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner's Code of Consumers' Rights (the Code). Residents' cultural needs are assessed with interventions outlined in the care plan. Policies are implemented to support residents' rights, communication, and complaints management. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns have been managed and a complaints register is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

Summerset by the Park has a documented quality and risk management system. Key components of the quality management system are reported monthly to head office. Annual surveys and monthly resident meetings provide residents and families with an opportunity for feedback about the service. Quality performance data on incidents, infections and internal audit results is collated monthly and tabled at relevant meetings. Quality data is benchmarked against others in the Summerset group. Health and safety

policies, systems and processes are implemented to manage risk. Falls prevention strategies are in place that includes the analysis of falls incidents.

There are human resources policies including recruitment, selection, orientation and staff training and development. There is an annual education and training programme in place. Appropriate employment processes are adhered to and all employees have an annual staff appraisal completed.

There is a staffing policy in place. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

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.

There is an admission package available prior to or on entry to the service. Registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes, and goals with the resident and/or family input. Care plans viewed demonstrated service integration and are reviewed at least six-monthly. Resident files include medical notes by the contracted general practitioners.

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

The diversional therapist implements the activity programme to meet the individual needs, preferences, and abilities of the residents. Residents are encouraged to maintain community links noting that there have been restrictions because of the Covid 19 national response.

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

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.

The building has a current warrant of fitness. There is a preventative and planned maintenance schedule in place. Chemicals are stored safely throughout the facility. All bedrooms except one have ensuites. There is sufficient space to allow the movement of residents around the facility using mobility aids or lazy boy chairs. The hallways and communal areas are spacious and accessible.

The outdoor areas are safe and easily accessible by lifts that take residents to the ground floor. There is an approved fire evacuation scheme. There are six-monthly fire drills. Staff have attended emergency and disaster management. The environment is warm and comfortable. Housekeeping staff maintain a clean and tidy environment. Systems and supplies are in place for essential, emergency and security services.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.

Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort. Staff receive regular education and training on restraint minimisation. There were no residents requiring the use of a restraint. Two residents were using an enabler at the time of audit.

Infection prevention and control

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

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator is responsible for the collation of infections and orientation and education for staff. There is a suite of infection control policies and guidelines to support practice. Information obtained through surveillance is used to determine infection control activities and education needs within the facility. There has been one outbreak since the previous audit.

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	42	0	2	1	0	0
Criteria	0	90	0	2	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The service provides information to residents that includes the Code of Health and Disability Services Consumer Rights (the Code), complaints, and advocacy information. Information is given to next of kin or EPOA to read to and/or discuss with the resident. Interviews with 10 residents (five hospital and five rest home including one in a serviced apartment) and relatives (three with family identified as requiring hospital level of care) identified they are well informed about the code of rights. Observations during the audit confirmed this in practice. The information pack provided to residents on entry includes how to make a complaint, the pamphlet on the Code, advocacy, and information around the Health and Disability Commission. The families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement. Discussions with the managers (clinical nurse leader, village manager, regional quality manager) and 15 staff (four caregivers, five registered nurses (RN), one diversional therapist, one laundry staff, two cleaners, one physiotherapist, one maintenance) confirmed their familiarity with the Code.
Standard 1.1.10: Informed Consent	FA	Informed consent processes were discussed with residents and families on admission. Eight electronic resident files contained written general consents for photographs, release of medical information and

Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.		medical cares, which were included in the admission agreement. These are signed as part of the admission process. Specific consent had been signed by resident/relatives for procedures such as the influenza and Covid vaccines. Discussions with care staff confirmed that they are familiar with the requirements to obtain informed consent for entering rooms and personal care. Enduring power of attorney (EPOA) evidence is filed in the residents' electronic charts and activated as applicable when residents were assessed as incompetent to make an informed decision. EPOA were not required to be activated in files reviewed. Advance directives for health care including resuscitation status and medical interventions had been completed by residents deemed to be competent. All eight resident records reviewed had advance directives signed by the resident. Discussion with family members identified that the service actively involves them in decisions that affect their relative's lives. Discussions with staff confirmed that they are familiar with the requirement to obtain informed consent for entering rooms and for the provision of personal cares on a daily basis.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	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 relatives confirmed the service provided opportunities for the family/enduring power of attorney (EPOA) to be involved in decisions. The resident files included information on residents' family/whānau and chosen social networks. An advocate from the village (independent to the care centre) is also able to support a resident if required.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Interviews with residents and relatives confirmed that visiting can occur at any time within parameters set because of Covid 19. The service had reopened visiting on the day of audit as they had completed the appropriate lockdown following a Covid 19 case. All residents and family interviewed confirmed that relative/family visiting occurs as per current Covid guidelines which allow fully vaccinated visitors in the facility. Due to current guidelines, there are no entertainers or outside groups allowed onto the premises. Key people involved in the resident's life are documented in the care plans.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood,	FA	The organisation has a complaints policy that describes the management of the complaints process. There are complaints forms available at reception that provide links to HDC advocacy services. Complaints forms are available from reception and booklets describing the complaints process are published and available in public areas. Interviews with residents and families demonstrated an understanding of the complaints process. Staff interviewed were able to describe the process around

respected, and upheld.		reporting complaints. There is an electronic complaint register that is held by the village manager. Verbal and written complaints are documented. All complaints reviewed had noted investigation, timeframes, corrective actions when required and were signed off as resolved. Results are fed back to complainants and are discussed at relevant meetings. There were 13 complaints in 2021 and two in 2022 year to date. Electronic complaint documentation included follow-up letters and resolutions were completed within the required timeframes. There have not been any external complaints since the last audit.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	The service has a philosophy that promotes quality of life and involves residents in decisions about their care, respects their rights and maintains privacy and individuality. Details relating to the Code and the Health and Disability Advocacy Service are included in the resident information folder that is provided to new residents and their families. The village and/or clinical nurse leader discusses aspects of the Code with residents and their family on admission. Residents interviewed confirmed that they received cares that met their needs, and all were aware of their rights. Family members interviewed confirmed that staff had informed them of the Code.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	The service has a philosophy that promotes quality of life and involves residents in decisions about their care, respects their rights and maintains privacy and individuality. The clinical nurse leader and staff support residents to go to their choice of spiritual/religious advisors with the support of family. Spiritual services are offered on site however these had stopped during an outbreak and during lock down as per pandemic requirements. The services have just restarted with residents also able to zoom to link into personal spiritual services. Religious dietary requirements when identified through assessment and care planning are met as required. The assessment and care plan includes identification of spiritual and religious needs and interventions. Discussions with residents confirmed the staff are respectful, that their privacy is respected, and that cultural and/or spiritual values and individual preferences are identified. There are two of three double rooms occupied. One is occupied by one resident and there is a couple in the other shared room. Curtains are up to separate residents if they wish. The residents in the shared room interviewed stated that they were able to have personal space and privacy whenever they wished. They also stated that staff were very conscious of privacy needs and always knocked and waited to be invited into the room.

		One single room is currently being used on a temporary basis for a couple to sleep in. This arrangement has been sanctioned by the district health board. The couple also has a single room available to use as a lounge. There is an implemented abuse and neglect policy. Staff have completed training around abuse and neglect as part of orientation and ongoing training and could describe appropriate practices to prevent and identify any abuse or neglect. There have not been any incidents related to abuse or neglect since the last audit. The general practitioner (GP) praised the service for the way services were delivered and stated that there was no evidence of abuse or neglect.
Standard 1.1.4: Recognition Of Māori Values And Beliefs 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.	FA	Summerset by the Park 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. Maori providers in the community are identified. At the time of audit there were no residents who identified as Māori. There is one staff member who identifies as Maori/Pakeha. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with disability and other community representative groups as requested by the resident/family. Cultural needs are addressed in the care plan. Staff interviewed could describe how they can ensure they meet the cultural needs of Māori.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	An initial care planning meeting is carried out where the resident and/or family/whānau as appropriate/able are invited to be involved. Individual beliefs or values are further discussed and incorporated into the care plan. Six-monthly multidisciplinary team meetings occur to assess if needs are being met. Family are invited to attend. Discussions with relatives confirmed values and beliefs are considered. Residents interviewed confirmed that staff consider their culture and values. There are four residents who identify as Indian and one Pacific Island. One resident interviewed who identified with one of these ethnicities was very satisfied with the service and stated that cultural needs were met. Specific food to meet the needs of these residents can be provided. One resident was observed to be eating food appropriate to their cultural needs on the days of audit.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion,	FA	There are implemented policies and procedures to protect clients from abuse, including discrimination, coercion, harassment, and exploitation, along with actions to be taken if there is inappropriate or unlawful conduct. Expected staff practice is outlined in job descriptions. Staff interviewed demonstrated

harassment, sexual, financial, or other exploitation.		an awareness of the importance of maintaining professional boundaries with residents. Residents interviewed stated that they have not experienced any discrimination, coercion, bullying, sexual harassment, or financial exploitation. Professional boundaries are reconfirmed through education and training sessions, staff meetings, and managers state that performance management would address any concerns if there was discrimination noted.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service meets the individualised needs of residents who have been assessed as requiring rest home or hospital level of care as confirmed through interviews with care staff and through an audit of resident files. The service has policies and procedures, equipment, and resources to support ongoing care of residents. The quality programme has been designed to monitor contractual and standards compliance and the quality-of-service delivery in the facility. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. Meetings are conducted to allow for timely discussion of service delivery and quality of service including health and safety. Residents and family members interviewed spoke very positively about the care and support provided. Both family and residents interviewed stated that the managers were very visible and encouraged open discussion at all times. Staff interviewed had a sound understanding of principles of aged care and person-centred care. Caregivers' complete competencies relevant to their practice. The general practitioner interviewed is satisfied with the care that is being provided by the service and stated that electronic systems in place supported good practice.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents interviewed, confirmed they were given an explanation about the services and procedures and were orientated to the facility as part of the entry process. They also stated their relatives are informed of changes in health status and incidents/accidents with family interviewed confirming that they were kept informed at all times (one exception to this in family interviews where the family member stated that staff could be more proactive). A review of 16 incident forms confirmed that family were informed in a timely manner when incidents occurred. Resident and family meetings were occurring monthly. Lock down restrictions because of Covid 19 have stopped the service holding some meetings in 2021. These have been restarted in 2022. An independent advocate from the village facilitates discussions at the resident/family meeting three monthly. Residents and family confirm that they find the meetings useful and provide opportunities to raise issues or concerns. Residents and family interviewed confirmed that the managers have an open-door policy and resolve concerns proactively. They particularly praised the village manager for the responsiveness to any issues.

		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 including staff who speak Indian and Pacific languages. There are no residents currently requiring the use of interpreting services as residents who cannot speak English well are supported by family as well as by staff who speak their language.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	PA Low	Summerset by the Park is certified to provide rest home and hospital (geriatric and medical) level care in their care facility. There are 55 dual purpose beds on level three and one room designated as a respite bed (rest home level of care) on level two. There are also 55 apartments able to be used for residents requiring rest home level of care (across level two and level three). Of these apartments, 27 are called serviced apartments (single occupancy) and 28 are called independent apartments (two bed units). Summerset by the Park can only have a total of 55 residents in the serviced or independent apartments at any given time. On the day of the audit, there were 58 residents. Of the 58, there were 21 residents requiring rest home level care (including one under a respite level of care contract and 37 requiring hospital level care (including two funded by ACC). Eight of the residents requiring rest home level of care are residing in serviced or independent apartments. All residents unless identified as above, are under the age-related residential care (ARRC) contract. The Summerset Group Limited Board of Directors have overall financial and governance responsibility and there is a company strategic business plan in place. The organisation is guided by a philosophy, vision, and values. The site specific 2021 business plan (which includes the quality plan) was developed in consultation with the village manager and regional operations manager (ROM) with this including goals, business requirements and benefits and measures of success. Quarterly reviews and an annual review have not occurred as scheduled in 2021. The 2022 business plan is currently being developed. The village manager (registered nurse with a background in emergency nursing) was the care centre manager for five years and has been promoted recently. A care centre manager has been appointed and is due to start after the audit. Two clinical nurse leaders support the village manager. One has been in the role for three years, with a further 17 years' experience at another aged care provider. The second clinical nurse leader has been in the role for 18 months and has a background in community nursing. The regional quality manager has worked for over 20 years in aged care and provides support for both the clinical leaders and the village manager. They were on site during the audit. Village managers and care centre managers

		attend annual organisational forums and regional forums over the year with zoom meetings held at relevant times during the Covid 19 pandemic. There is a regional operations manager who also supports the facility and staff. The village manager has attended at least eight hours of leadership professional development relevant to the role.
Standard 1.2.2: Service Management 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.	FA	During a temporary absence, the village manager will cover the care centre manager's role. The regional quality manager and the regional operations manager would also cover the village manager's role should that be required with continued oversight and support provided currently. The audit confirmed the service has operational management strategies to minimise risk of unwanted events.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Low	Summerset by the Park has a documented 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. The Summerset group has a 'clinical audit, training and compliance' calendar. The calendar schedules the training and audit requirements for the month and the care centre completes a 'monthly report to the regional quality manager. The report includes meetings held, induction/orientation, audits, competencies, and projects and is forwarded to head office as part of the ongoing monitoring programme. A range of data (e.g. falls, skin tears, other incidents, infections complaints, staff incidents, falls, medication errors) are collected, collated, and analysed monthly by the village manager (as the care centre manager has not yet started in the role). Results are shared online with head office and data is tabled in meetings e.g. the monthly registered nurse, staff, quality and health and safety meetings. There are other facility meetings held such as maintenance and activities. While data is tabled, there is no evidence in meeting minutes to confirm that discussion has occurred at the meetings. An internal audit programme schedule includes monthly audits which have been completed as planned in 2021. Corrective actions raised as a result, evidenced these have been completed as required. The annual resident/family satisfaction survey was completed in 2020 and 2021. The overall satisfaction in 2020 was 96.1% with a net promoter score of 47.5. The overall satisfaction in 2021 was

		99.4% with a net promoter score of 66.7. There is a corrective action plan around food services following concerns raised in the surveys. Summerset by the Park was identified as the care centre of the year for 2021. There is a health and safety and risk management programme in place including policies to guide practice. There are three health and safety representatives. Staff were aware that they could talk with a health and safety representative if required. The hazard register is current and is updated to reflect risks as these arise. All staff and contractors receive a health and safety induction. 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.
Standard 1.2.4: Adverse Event Reporting 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.	PA Moderate	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. The service collects a set of data relating to adverse, unplanned, and untoward events, which is linked to the quality and risk management system. Fifteen incidents reviewed confirmed that immediate actions were documented on the electronic accident/incident database. Each incident is recorded against an individual resident, then incidents are totalled according to category. Incidents and accidents are investigated by the clinical nurse leader or village manager. These reviews are signed off in a timely manner by the manager responsible. Family are also confirmed as being notified in a timely manner. Of the 15 incidents reviewed, seven were for a resident with an unwitnessed fall and/or had hit their head. Neurological observations are not taken as per the frequency defined in the policy. There were eight section 31 notifications made in 2021 and 2022 for pressure injuries and resident behaviour. A section 31 as also put through to HealthCERT and the DHB of a Covid 19 positive case in the facility in 2022.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	There are human resources policies to support recruitment practices. A list of practising certificates is maintained. Eight staff files (one clinical nurse lead, three RNs, one diversional therapist, two caregivers, one maintenance,) were reviewed and all had relevant documentation relating to employment. Performance appraisals had been completed annually for those staff who have been employed for over 12 months. 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 (sighted in files of newly appointed staff). 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'. The plan is being implemented. Additional training has been delivered to both RNs and care staff in response to identified needs. RNs also have training online. A competency programme is in place with different requirements according to work type (e.g. caregivers and registered nurse). Core competencies are completed, and a record of completion is maintained on staff files and on an electronic human resources database. Staff interviewed were aware of the requirement to complete competency training and stated they were actively encouraged to achieve New Zealand qualifications through Careerforce training. Of the 36 caregivers employed five caregivers have level 2 NZQA; 10 with level 3; six with level 4 NZQA qualifications. There are 10 RNs with eight interRAI trained. There are two clinical nurse leaders who are also interRAI trained. External education is provided, and RNs are linked to the PDRP (professional development recognition programme) at the DHB. RNs can access training through the DHB and as provided by other health providers such as Hospice.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	The village manager (and care centre manager when they start) work 40 hours per week Monday to Friday and are available on call for any emergency issues or clinical support. The clinical nurse leaders work 40 hours a week and between them cover seven days a week. In the care centre, there are two RNs on duty in the morning and afternoon (one in the morning has office duties) and a registered nurse overnight. There are nine caregivers on morning shifts (five long shifts and four short shifts); nine on the afternoon shift (four long and five short) and two on night shift. The caregivers are allocated to two wings as follows: Wing one (20 hospital and 8 rest home residents): AM – five caregivers (one long and two short), PM – five caregivers (two long and three short). Wing two (17 hospital and five rest home residents): AM – four caregivers (two long and two short), PM – four caregivers (two long and two short). One caregiver is allocated to wing one overnight and one to wing two overnight. The serviced or independent apartments with rest home residents (eight currently) have one caregiver from 7am-3pm, one from 4.30pm-10pm and one form 11pm to 7am (they also do cleaning duties). One of the short shift caregivers on PM is allocated to attend to any call bell for a resident in a serviced

		apartment if the allocated caregiver is not on (1.5 hours). Staffing levels and skills mix policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery. A staff availability list ensures that staff sickness and vacant shifts are covered. Caregivers interviewed confirmed that staff are replaced when off sick. Interviews with residents and relatives confirmed that staffing levels are sufficient to meet the needs of residents.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The resident files were appropriate to the service type. Residents entering the service have all relevant initial information recorded. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access by being securely stored electronically. Care plans were digitally signed (and dated) by a registered nurse. Progress note entries are dated and digitally signed by the relevant caregiver or registered nurse. Individual resident files demonstrate service integration. Records contained general practitioner notes and the notes of allied health professionals and specialists involved in the care of the resident.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	There are policies and procedures to safely guide service provision and entry to services including an admission policy. The service has an information pack available for residents/families at entry. The admission agreements reviewed met the requirements of the ARRC contract. Exclusions from the service are included in the admission agreement. All long-term admission agreements sighted were signed and dated.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	A policy describes guidelines for death, discharge, transfer, documentation and follow up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. The facility uses the CMDHB 'yellow envelope transfer system. Communication with family is made.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that	FA	There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were no residents self-administering on the day of audit. There are no standing orders. There are no vaccines stored on site. The facility uses an electronic and robotic pack system. Medications are checked on arrival and any

complies with current legislative requirements and safe practice guidelines.		pharmacy errors recorded and fed back to the supplying pharmacy. Registered nurses and senior medication competent caregivers administer all medications. Staff attend annual education and have an annual medication competency completed. All RNs are syringe driver trained by the hospice. The medication fridge and room temperatures are checked weekly and were within ranges. Eye drops are dated once opened. Staff sign for the administration of medications on the electronic system. Sixteen medication charts were reviewed (ten hospital and six rest home). Medications are reviewed at least three-monthly by the GP. There was photo identification and allergy status recorded. 'As required' medications had indications for use charted with evidence of effectiveness documented in the individual resident's progress notes.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	Food service is currently contracted to an external provider. The kitchen staff work in two teams and each team does not have contact with the other because of the need to separate staff because of Covid 19. A team consists of a cook and two kitchen hands, one of whom does the baking. All kitchen staff have current food safety certificates. The head cook oversees the procurement of the food and management of the kitchen. There is a well-equipped kitchen, and all meals are cooked on site. Meals are transported to the dining room in hot boxes and served from a dining room servery. The temperature of the food is checked before serving. Special equipment such as lipped plates is available. On the first day of audit there was a 'Ploughman's' lunch and residents stated that they were enjoying it. They also stated that they could ask for more if required. If residents do not like what is on the menu, they may ask for a sandwich or soup. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures were monitored and recorded weekly. Food temperatures are checked, and these were all within safe limits. The residents have a nutritional profile developed on admission which identifies dietary requirements, likes, and dislikes. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes were noted. Indian residents may order a curry. The weekly menu cycle is approved by a dietitian. Some residents/families interviewed were satisfied with the meals and others were dissatisfied. The facility has implemented an action plan to address issues raised. The food control plan is dated 3 March 2021.
Standard 1.3.2: Declining	FA	The service records the reason for declining service entry to residents should this occur and

Referral/Entry To Services 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.		communicates this to residents/family. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. InterRAI assessments had been completed for all long- term residents whose files were sampled. The goals were identified through the assessment process and linked to electronic care plan interventions. There was an initial assessment and short-term care plan for the respite resident. Other assessment tools in use included nutrition, falls, pressure injury, pain, and culture. Assessments are also completed when there is a change in health status or incident and as part of completing the six-month care plan review. When assessments are due these are automatically scheduled in the RN's electronic daily calendar.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The electronic care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans are resident-centred. Interventions documented support needs and provide detail to guide care. Short-term care plans are in use for changes in health status. Residents and relatives interviewed stated that they were involved in the care planning process. There was evidence of service integration with documented input from a range of specialist care professionals including the hospice nurse, wound care nurse and mental health care team for older people. The care staff interviewed advised that the care plans were easy to follow.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	When a resident's condition changes, the RN initiates a GP consultation. Staff stated that they notify family members about any changes in their relative's health status. All care plans 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. Resident falls are reported on electronic accident forms and written in the progress notes. Neurological observations are not taken as per policy when there is a head injury or for an unwitnessed fall (link 1.2.4.3). Care staff interviewed stated that there are adequate clinical supplies and equipment provided including

		continence, wound care supplies and personal protection equipment (PPE) Electronic wound assessment, wound management and wound evaluation forms are in place for all wounds. Wound monitoring occurs as planned. There are currently four wounds being treated i.e. three skin tears and one chronic wound. There were also four pressure injuries; one stage 2, two stage 3 (all facility acquired) and one non- facility acquired unstageable pressure injury. The stage three and unstageable pressure injuries were reported on a section 31 to HealthCERT. Pressure injury prevention equipment is available and in use. Wounds due for dressing changes are triggered electronically on a daily basis. 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. One resident had challenging behaviour (wandering within the facility) however, a behavioural chart was not required to be used, as there is no agitation or aggression and interventions documented in the care plan were being used to manage the wandering.
Standard 1.3.7: Planned Activities 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.	FA	There is a diversional therapist who works 40 hours a week and a recreational officer who works 32 hours a week. On the day of audit residents were observed listening to a newspaper reading, participating in 'stretch it' exercises and playing bingo. There is a monthly programme in large print in each resident's room and a weekly programme in large print on all noticeboards. 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 one-on-one visits to check if there is anything they need or to have a chat. Pre-Covid there was an interdenominational and a Catholic church service every week. Currently there is an online service every Sunday and residents may phone their pastors/priests if requested. Pre-Covid there was community input from local pre-schools and junior colleges as well as choirs and dance groups. Residents were able to go out shopping, on outings, to cafés for coffees, on picnics and for ice-creams. Although outside entertainers cannot currently come into the facility because of the implementation of the Covid 19 framework, activities are held on site. Special events like birthdays, Chinese New Year. Easter, Mother's Day, Anzac Day, and the Melbourne Cup are celebrated. Happy hour is every Friday and there is entertainment at this every second week. There are two facility budgies which are cared for by a resident. Residents are scheduled to 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 individual activity plan is based on this assessment. Activity plans are scheduled to be evaluated at least six-monthly at the same time as the review of the long-term care plan.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Seven of the eight long-term care plans reviewed had been evaluated by the registered nurse six-monthly or when changes to care occurred (noting that the resident using respite services was not required to have a care plan evaluated). Resident goals are reviewed at resident review meetings. Short-term care plans for short- term needs are evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. The multidisciplinary review involves the RN, GP, and resident/family if they wish to attend. There is at least a three-monthly review by the GP. The family members interviewed confirmed that they are informed of any changes to the care plan.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where residents had been referred to the wound care nurse specialist, mental health services for older people, the dietitian, and the hospice. Discussion with the registered nurse identified that the service has access to a wide range of support either through the GP, specialists, and allied health services as required.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	There are implemented policies to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles are available for all care staff and laundry/housekeeping staff. Infection control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals are labelled correctly and stored safely throughout the facility. Safety datasheets and product information is available. The chemical provider monitors the effectiveness of chemicals and provides chemical safety training.
Standard 1.4.2: Facility Specifications	FA	The building is on three levels with the care centre on the third floor and serviced apartments on all three levels. The building has a current building warrant of fitness that expires on 17 April 2022.

Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.		There is a full- time maintenance person who has two assistants. There are contracted gardeners, plumbers, and electricians. Maintenance requests are generated through the on-line system and closed off when completed. There is a monthly maintenance plan that includes environmental, building, and resident equipment checks. Electrical equipment has been tested and tagged. Clinical equipment including hoists and weigh scales, have been calibrated. Hot water checks in resident areas are checked and documented monthly. They are within an acceptable range. 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, however, residents have to use the lift to go outside. Outdoor areas provide seating and shade. The external areas are well maintained. The activities staff have made a small inside garden off the lounge which the residents enjoy. There is a small room with physiotherapy and gym equipment. One resident uses this daily. There are two lifts, one lift is large enough to accommodate beds/stretchers. The caregivers interviewed confirmed there is adequate equipment to carry out the cares, according to the resident needs, as identified in the care plans.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities 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.	FA	All resident rooms but one (including the serviced or independent apartments) have full toilet/shower ensuites. The one room without an ensuite has a bathroom across the corridor and this is reserved for that resident only. There are adequate numbers of communal toilets located near the communal areas. Toilets have privacy locks. Non-slip flooring and handrails are in place. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	There are three double rooms. These rooms have a privacy curtain dividing the bed space. All other rooms are single. There is one married couple temporarily sharing a single room. The room is sufficiently spacious to accommodate this, and permission has been granted by the DHB. Privacy screens are available if required. All bedrooms and ensuites are spacious for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.

Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	The care centre has a large open-plan lounge area with a dining area and kitchenette. On one side is a spacious lounge and the other side is the dining area. There is a conservatory off the lounge, and this is where the inside garden is situated. One end is currently being used as another dining room while wings one and two are separated. The open plan lounge is large enough for individual or group activities. All serviced apartments also have their own spacious lounge and kitchenette. The ground floor level includes a library, café, and hair salon.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	Summerset by the Park has documented systems for monitoring the effectiveness and compliance with the service policies and procedures. The laundry is located in the lower ground service area. The laundry has a double door and has an entry and exit with defined clean/dirty areas. Dirty linen is delivered to the laundry by a chute. The exception to this is infected linen which is delivered to the door of the laundry in yellow bags. All linen and personal clothing is laundered on site. There is one full time laundry worker and one part time. Between them they cover seven days a week. All laundry is sorted prior to washing. There are large commercial washing machines and dryers. There is a large folding table and laundry is placed into a delivery trolley for distribution to resident rooms. The service has a secure area for the storage of cleaning and laundry chemicals in the laundry. Material safety datasheets are readily accessible. Cleaners were observed wearing appropriate protective clothing while carrying out their duties. Cleaners' trolleys were well equipped, and all chemical bottles had the correct manufacturer's labels. Each cleaning trolley has a locked box where chemicals are stored. Cleaners' trolleys are kept in locked cupboards when not in use. There are two sluice rooms one on each side of the care centre level. Each sluice room has a sanitiser. Residents interviewed stated they are happy with the cleanliness of their bedrooms and communal areas. Other feedback is received through resident meetings and results of internal audits. The chemical provider conducts monthly quality control checks on the equipment and efficiency of chemicals in the laundry and housekeeping areas. They also provide chemical safety training.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response	FA	There is an emergency and evacuation procedures and responsibilities plan in place. A fire evacuation plan is in place that has been approved by the New Zealand Fire Service in June 2009. A fire evacuation drill is completed six-monthly. A contracted service provides checking of all facility equipment including fire equipment. Fire training and security situations are part of orientation of new staff and include competency assessments.

during emergency and security situations.		There are adequate supplies in the event of a civil defence emergency including emergency power back up, access to a generator, civil defence and first aid kits, food, water (large water tanks), blankets and gas cooking (gas hobs and a gas BBQ), and the facility has access to a generator. There are also sufficient supplies of outbreak/pandemic and personal protection equipment (PPE) available. A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) was rostered on each shift. Some staff have not been able to renew their first aid certificates which expired in December 2021 as Auckland had been in lockdown and the service was locked down in 2022 because of a case of Covid 19. The first aid trainer has been booked for February 2022. There are call bells in the residents' rooms, and lounge/dining room areas which are linked to cell phones. Call bells are monitored. There are security procedures in place
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	All bedrooms and communal areas have ample natural light and ventilation. There is gas underfloor heating throughout the facility. Staff and residents interviewed stated that this is effective. Due to the very hot summer the facility has installed large air coolers in the corridors. Residents and staff interviewed have expressed gratitude for these. All internal areas are smoke free. There is an external smoking area, but smoking is not encouraged.
Standard 3.1: Infection control management 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.	FA	The infection prevention and control programme is appropriate for the size and complexity of the service. An infection control coordinator (RN) is responsible for infection control across the facility. A job description outlines the role and responsibilities. The infection prevention and control committee meet monthly and comprises of a cross section of staff. The infection control coordinator provides monthly reports to head office and to the full facility meetings. The programme is set out annually from head office and directed via the quality programme. The programme is reviewed annually by head office. All visitors and contractors are required to complete an electronic health declaration which also serves as contact tracing. They have to wear masks and have vaccination passes checked. All residents and staff are vaccinated against Covid19. All residents transferring from hospital or the community are screened prior to admission. There are adequate hand sanitisers and signage throughout the facility. There is an outbreak management bin and an ample stock of personal protective equipment that is checked weekly. Care staff stated that they are very grateful that they have such ample stocks of PPE Staff and residents are offered an annual influenza vaccine

Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The infection control coordinator has completed online DHB and Summerset infection control education. This is updated annually. During Covid19 there has been regular information from head office. The facility has access to an infection control nurse specialist through the DHB, public health, GP's, local laboratory, and expertise from within the Summerset company/head office.
Standard 3.3: Policies and procedures 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.	FA	There are comprehensive infection prevention and control policies that are current and reflected the Infection Prevention and Control Standard SNZ HB 8134:2008, legislation and good practice. These policies are developed by head office. The infection prevention and control policies link to other documentation and cross reference where appropriate. There is ample resource information and plans around Covid 19 from head office with this provided to staff at the facility.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control coordinator is responsible for coordinating/providing education and training to staff. Training has been provided to staff in the past year. The infection control coordinator has completed training around infection control in the past year. The orientation/induction package includes specific training around hand hygiene and standard precautions, and training is provided both at orientation and as part of the annual training schedule. All staff complete hand hygiene audits six monthly. In-services have been provided around personal protective equipment and outbreak management and there has been particular emphasis on this since Covid19. Infection control is an agenda item on the full facility and clinical meeting agenda. Any new communication re Covid19 is relayed to staff re noticeboards and at handovers. Resident education occurs as part of providing daily cares. Care plans include ways to assist staff in ensuring this occurs.

Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Policies and procedures document infection prevention and control surveillance methods. The surveillance data is collected and analysed monthly to identify areas for improvement or corrective action requirements. Data is tabled at relevant meetings including staff and registered nurse meetings (link 1.2.3.6). Summerset collects data on Power B1, and results are benchmarked with other Summerset facilities. Infection control internal audits have been completed. Infection rates have generally been low. The pandemic plan has been updated to include Covid19. The service has process and procedures implemented to manage the risk posed by Covid19 and this proved invaluable in a recent outbreak. There has been continuing education around personal protective equipment (PPE) with emphasis on donning and doffing of gowns and gloves. There has also been continuing education on hand hygiene, what to do for an outbreak and staff wellness. There is Covid information on both staff and resident noticeboards. The infection control coordinator provides any new information on Covid-19 at handover. During lockdown residents were kept in their respective wings and staff were assigned to the same areas. The facility identified one person in the facility with Covid19 in January 2022. The village manager was notified by the public health department and immediately closed the care centre to visitors and admissions. All staff and residents had a rapid antigen test (RAT) that day and the next day a polymerase chain reaction test (PCR). All were negative. Testing still continues twice weekly. Staff wore full PPE until all negative tests in but now wear masks and face shields only. The relevant parts of the site were deep cleaned. Staff and residents are continuing to be monitored for any flu like symptoms and temperatures are checked daily.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	There are policies around restraints and enablers. There were no residents requiring the use of a restraint. Two residents were using an enabler (one with a lap belt and one with a bedrail). Both resident records reviewed showed that the residents had given consent for the use of the enabler and risks of use and interventions were documented in the care plan. Use of the enabler was reviewed monthly. Staff receive training around restraint minimisation that includes annual competency assessments.

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)
Criterion 1.2.1.1 The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.	PA Low	A business plan for the year is implemented in January each year (noting that in 2022, the development of the business plan had been delayed until February because the service had been in lockdown with a Covid 19 case). The documented plan documents goals and a range of action plans are developed for each goal. Responsibilities and timeframes are assigned. A plan for 2021 was sighted. Quarterly reports had not been fully completed.	The business plan for 2021 has not been reviewed quarterly or annually.	Ensure business goals are reviewed quarterly and annually as per policy. 90 days
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	All meeting minutes were reviewed for 2021 and 2022. The meetings minutes included documentation of data around clinical indicators (e.g. incident trends, infection rates, benchmarking results with other Summerset villages), internal audits, complaints etc as standard agenda items. Minutes do not evidence discussion of quality data.	While data is tabled at meetings, there is no evidence that the data is discussed and used for improvements to the service.	Document evidence of discussion of data and improvements made as a result of these discussions. 90 days

Criterion 1.2.4.3 The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.	PA Moderate	There is a policy around completion of neurological observations if a resident has an unwitnessed fall and/or hits their head. Seven incidents were reviewed (January 2022) for a resident who had an unwitnessed fall and/or had hit their head. Neurological observations were completed for approximately four to eight hours, however the policy states that these should continue for 24 hours.	Neurological observations for a resident who has an unwitnessed fall and/or hits their head were not completed according to the frequency stated in the policy.	Ensure that neurological observations for a resident who has an unwitnessed fall and/or hits their head are completed according to the frequency stated in the policy. 90 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.