

Summerset Care Limited - Summerset in the Vines

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 in the Vines
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 9 February 2022 End date: 10 February 2022
Proposed changes to current services (if any):	Merlot wing (16 beds) is temporarily closed from 25 September 2021 due to a fire event.
Total beds occupied across all premises included in the audit on the first day of the audit:	25



Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Summerset in the Vines is certified to provide hospital and rest home level care for up to 43 residents. On the day of the audit there were 25 residents in total. A wing of 16 beds is temporarily closed for refurbishment due to a fire event. On the day of the audit there were 25 residents in total.

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 service is managed by a village manager who has been in the role for seven years. The village manager is supported by a care centre manager who has been in the position for 20 months. The care centre manager is supported by the clinical nurse lead. Management are supported by a regional operations manager and regional quality manager. The residents and relatives interviewed spoke positively about the care and support provided.

There were no areas for improvement identified at this audit.

The service is commended for achieving continuous improvement ratings around quality data, activities, restraint, and infection surveillance.

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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The service functions in a way that complies with the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and related services are readily available to residents and families. Residents and where appropriate their family/whānau are being provided with appropriate information to assist them to make informed choices and give informed consent. Policies are available that support residents' rights. Cultural assessment is undertaken on admission and during the review process. Care plans accommodate the choices of residents and/or their family. Complaints processes are being addressed in line with HDC requirements.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Summerset in the Vines 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 (but not limited to) monthly quality improvement meetings. Annual surveys and regular resident meetings provide residents and families with opportunities for feedback about the service. Quality performance is reported to staff at meetings and includes discussions relating to incidents, infections, and internal audit results. There are human resources policies that cover 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 with safe staffing levels implemented.

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.

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

The service uses an electronic patient management system. There is a well-developed information pack available for residents and families/whānau at entry. Assessments, long-term care plans and evaluations were completed by the registered nurses and risk assessment tools and monitoring forms were available and implemented. A diversional therapist plans and implements the activity programme. The activities meet the individual recreational needs and preferences of the consumer groups. There are outings into the community and when no covid restrictions, 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 contract 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.

There were documented processes for the management of waste and hazardous substances in place and incidents are reported in a timely manner. Chemicals were stored safely throughout the facility. The building has a current warrant of fitness. Resident

bedrooms are spacious and personalised. There is a mix of bedrooms with ensembles, shared ensembles or access to 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. All laundry and linen services are completed on-site. There is plenty of natural light in all rooms and the environment is comfortable with adequate ventilation and heating.

Restraint minimisation and safe practice

<p>Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.</p>		<p>All standards applicable to this service fully attained with some standards exceeded.</p>
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Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort. At the time of the audit there was one resident assessed as requiring the use of restraint and two using enablers. Staff receive regular education and training on restraint minimisation.

Infection prevention and control

<p>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.</p>		<p>All standards applicable to this service fully attained with some standards exceeded.</p>
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The infection control programme is appropriate for the size and complexity of the service. The infection prevention and control coordinator is responsible for coordinating and providing education and training to staff. Ongoing training occurs annually as part of the training calendar. Care plans include infection prevention and control interventions as appropriate. The infection control manual outlined the scope of the programme and included a comprehensive range of policies and guidelines. Surveillance programme is implemented including 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	3	47	0	0	0	0	0
Criteria	4	97	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner's (HDC) Code of Health and Disability Consumers' Rights (the Code) brochures are accessible to residents and their families. The policy relating to the Code is implemented and observation during the audit confirmed this in practice. Staff interviewed (one village manager, one care centre manager, one regional quality manager, and one property manager five caregivers, six registered nurses (RN) (including the clinical lead), one diversional therapist, one laundry/housekeeper and two cooks) could describe how the Code is incorporated into their everyday delivery of care. Staff receive training about the Code during their induction to the service, which continues annually through the staff education and training programme, which was last completed in November 2021.</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</p>	FA	<p>Informed consent processes were discussed with residents and families on admission. Written general and specific consents were evident in the seven resident records (three rest home residents and</p>

<p>choices and give informed consent.</p>		<p>four hospital level residents). Caregivers, RNs, clinical nurse lead and the care centre manager interviewed, confirmed consent is obtained when delivering cares. Resuscitation orders are appropriately signed by the resident and general practitioner (GP) and discussion with the family is documented in the 'Shared Goals of Care' documentation. Discussion with family members identified that the service actively involves them in decisions that affect their relative's lives. Six long-term admission agreements were sighted and had been signed on admission.</p>
<p>Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Information on advocacy services is included in the resident information pack that is provided to new residents and their family on admission. Advocacy brochures are also available at reception. Interviews with residents and family confirmed their understanding of the availability of advocacy services. The complaints process is linked to advocacy services with this offered to any complainant if required. Staff receive regular education and training on the role of advocacy services, which begins during their induction to the service with training records confirming this. Discussions with relatives confirmed the service provides opportunities for the family/enduring power of attorney (EPOA) to be involved in decisions.</p>
<p>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.</p>	<p>FA</p>	<p>At the time of the audit relatives were able to visit as there were no Covid-19 level restrictions, Covid-19 procedures were in place around signing in with the vaccination pass and infection control protocol. Relatives/families are emailed or phoned during any Covid-19 lockdown restrictions. Relatives interviewed confirmed they received regular communication and updates regarding Covid-19 levels, restrictions, and associated infection control measures.</p>
<p>Standard 1.1.13: Complaints Management 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 an electronic complaint register that includes relevant information regarding the</p>

		<p>complaint. The number of complaints received each month is reported monthly to staff via the various meetings. There have been two complaints made in 2021 and one received in 2022 YTD. All complaints reviewed have been managed in line with Right 10 of the Code. A review of complaints documentation evidenced resolution of the complaint to the satisfaction of the complainant. Residents and family members advised that they are aware of the complaint's procedure. Staff interviewed were able to describe the complaints process. Discussion around concerns, complaints and compliments was evident in facility meeting minutes.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.</p>	FA	<p>The service provides information to residents that include the Code, complaints, and advocacy. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Seven residents interviewed (two rest home and five hospital) confirmed that they received cares that met their needs, and all were aware of their rights. Four relatives (one rest home and three hospital) were interviewed and confirmed that staff had informed them of the Code. Discussions relating to the Code are also held during the monthly resident/family meetings. An annual residents/relative's satisfaction survey is completed which evidence satisfaction around the resident's code of rights.</p>
<p>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.</p>	FA	<p>Staff interviewed could describe the procedures for maintaining confidentiality of resident records, resident's privacy, and dignity. The residents' personal belongings are used to decorate their rooms. House rules and a code of conduct are signed by staff at commencement of employment. The caregivers interviewed reported that they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas. This was observed to occur during the audit. Caregivers reported that they promote the residents' independence by encouraging them to be as active as possible. Contact details of spiritual/religious advisors are available. Resident files include cultural and spiritual values. All the residents and families</p>

		interviewed confirmed that residents' privacy is respected.
<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 in the Vines has a Māori health plan that includes a description of how they achieve the requirements set out in the contract. The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. There was one resident who identified as Māori at the time of the audit. The resident's file was reviewed and included Māori health plan, cultures, and preferences. Links are established with local Iwi and other community representative groups. Cultural needs are addressed in the care plan. Staff interviewed could describe how they can ensure they meet the cultural needs of Māori. Staff receive annual education on cultural awareness that begins during their induction to the service.</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. The service identifies the residents' personal needs and desires from the time of admission. This is achieved in collaboration with the resident, family and/or their representative. Staff interviewed confirmed that they are committed to ensuring each resident remains a person, even in a state of decline. 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. Residents and families interviewed confirmed they are involved in developing the residents plan of care, which includes the identification of individual values and beliefs.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>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. Staff job descriptions include responsibilities and staff sign a copy on employment. Staff interviewed demonstrated an awareness of the importance of maintaining professional boundaries</p>

		<p>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 and staff meetings. The village manager and care centre manager stated that performance management would address any concerns if there was discrimination noted.</p>
<p>Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service meets the individualised needs of residents who have been assessed as requiring rest home or hospital level care as identified through interviews with care staff and through an audit of resident files. Residents and relatives interviewed spoke very 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, care centre manager and clinical nurse lead. All Summerset facilities have a master copy of policies which have been developed in line with current accepted best practice and are reviewed regularly. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff. There is a quality improvement programme that includes performance monitoring against clinical indicators and benchmarking against like services within the group as well as other external aged care providers.</p> <p>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. There is a culture of ongoing staff development with an in-service programme being implemented. There is evidence of education being supported outside of the training plan. There are implemented competencies for caregivers and RNs including but not limited to: insulin administration, medication, wound care, and manual handling. RNs have access to external training. A strong teamwork approach encouraged by positive leadership and regular team building events fosters a culture of good practice. Staff interviewed had a sound understanding of principles of aged care and stated that they are supported by the management team. Caregivers'</p>

		complete competencies relevant to their practice.
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>There is a policy to guide staff on the process around open disclosure. The village manager and care centre manager confirmed family are kept informed. 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. The regional quality manager interviewed also stated that the managers discuss how they can improve resident outcomes on a regular basis. Residents/relatives have the opportunity to feedback on service delivery through annual surveys and open-door communication with management. Residents and family interviewed also confirmed that the care centre manager and the village manager are readily available and helpful.</p> <p>Resident/family meetings have occurred monthly (other than during the Covid-19 lockdowns/restriction levels). Accident/incident forms reviewed evidenced relatives are informed of any incidents/accidents. 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 with phone numbers identified in policy.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Summerset in the Vines is certified to provide care for up to 43 residents at hospital and rest home level care. All rooms are identified as dual-purpose. Currently Merlot wing (16 beds) has been temporarily closed since 25 September 2021 as a result of a fire event. On the day of the audit, there were 25 residents in total, nine residents at rest home level and 16 residents at hospital level. All residents were under the aged residential related care (ARRC) contract. Due to the temporary closure of the Merlot wing a full interior renovation of the Summerset in the Vines care centre is to commence in the first quarter of 2023.</p>

		<p>The Summerset Group Limited Board of Directors have overall financial and governance responsibility and there is a company strategic business plan in place. Summerset in the Vines has a site-specific business and quality plan 2022. Quality objectives include resident and staff satisfaction, high quality care, pandemic planning, and sustainability and social responsibility. There is a documented review of progress towards goals. Meeting minutes document review of quality outcomes.</p> <p>The village manager (non-clinical) has been in the role at Summerset in the Vines for seven years. The village manager is supported by a care centre manager and a clinical nurse lead. The care centre manager has been in the position for 20 months and has worked in a variety of clinical roles at Summerset for 12 years. The clinical nurse lead has been in the role for one year. There is a regional operations manager and regional quality manager (both present at the time of the audit) who are available to support the facility and staff.</p> <p>The village manager and care centre manager have attended at least eight hours of leadership professional development relevant to the role through the Summerset leadership programme.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>The care centre manager provides support for the service along with the regional quality manager and other head office staff if the village manager is on leave. The clinical nurse lead provides clinical oversight along with support from head office if the care centre manager is on leave. The regional quality manager provides oversight and support at any time.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>There is an established quality and risk management system. There are policies and procedures being implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. 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</p>

		<p>quality assurance framework 2022 calendar. The calendar schedules the training, meetings, and audit requirements for the month. Facility meetings held include weekly managers' meetings, staff meetings, and monthly RN and quality improvement meetings. The monthly quality improvement meeting minutes sighted, evidenced staff discussion around accident/incident data, health and safety, infection control, audit outcomes, concerns, and survey feedback. The service collates accident/incident and infection control data. Monthly comparisons include detailed trend analysis and graphs. The service has exceeded the standard around quality initiatives, data collation and analysis in relation to falls, skin tear and bruising incident reductions.</p> <p>An annual residents/relatives survey has been completed in 2021 with this reporting a 97.3% satisfaction rate. The 2022 survey is due to be held later in the year. Corrective actions were documented and show continued follow-up around: personal care (due to Covid-19), alternative meals, communication, the living environment, and range of activities. The service is implementing an internal audit programme that includes aspects of clinical care. Issues arising from internal audits are developed into corrective action plans with evidence of resolution of issues as these are identified. Monthly and annual analysis of results is completed and provided across the organisation. There are monthly accident/incident benchmarking reports completed by the care centre manager that break down the data collected across the rest home and hospital with this compared to other Summerset services of similar size and composition. Infection control is also included as part of benchmarking across the organisation. Health and safety internal audits are completed.</p> <p>There is a health and safety and risk management programme in place including policies to guide practice. There is a health and safety plan with evidence of review at the health and safety meetings. There are health and safety representatives. The service addresses health and safety by recording hazards and near misses into RMSS (risk management safety system), sharing of health and safety information and actively encourage staff input and feedback. There is a current site-specific hazard risk register. The service ensures that all new staff and any contractors are inducted to the health and safety programme with a health and safety competency completed by staff as part of</p>
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		orientation (staff records confirmed that these had been completed). Staff confirmed they are kept informed on health and safety matters at meetings. 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.
<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>	FA	<p>Incident and accident data is being collected and analysed. A review of 14 incident/accident forms identified they were all fully completed, including follow-up by a RN and that family had been notified. Post-falls assessments included neurological observations were completed as per policy for six unwitnessed falls with a potential head injury. Near misses are also reported through the incident reporting system. The incident reporting policy includes definitions and outlines responsibilities including immediate action, reporting, monitoring, and corrective action to minimise and debriefing. Post incident and accident review was noted to be very thorough with comprehensive RN review as well as root cause analysis for more serious incidents.</p> <p>The village manager and care centre manager were able to identify situations that would be reported to statutory authorities. There were four section 31 notifications made in 2021, including the fire event in the Merlot wing (link 1.2.1), two resident wandering incidents and one stage three pressure injury. Notification has also been made to Public Health authorities for two outbreaks (gastro and respiratory) in 2021.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are human resources policies to support recruitment practices. Seven staff files (one care centre manager, one clinical nurse lead, one RN, three caregivers and one diversional therapist) were reviewed and all had relevant documentation relating to employment. Performance appraisals have been completed annually for staff who had been employed for longer than one year. Copies of annual practising certificates are on file and a review confirmed that these were current including RNs and external providers requiring these. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and believed new staff</p>

		<p>were orientated well into the service. The orientation programme includes a buddy system with the new staff member working alongside an experienced care staff member.</p> <p>There is an annual education plan in place. The 2021 education plan has been completed and 2021 plan has been implemented. Staff stated that this is relevant to their role. There are 19 caregivers in total; Three have completed level four New Zealand Qualification Authority (NZQA) through Careerforce, five have completed level three and eight have completed level two training. A competency programme is in place with different requirements according to work type (e.g. caregivers, RNs, and kitchen). Core competencies are completed, with a record of completion maintained. Staff interviewed were aware of the requirement to complete competency training. The service has seven RNs (including the care centre manager and clinical nurse lead) and all seven were trained in interRAI. The registered nurses have access to external training through the DHB.</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>There is a safe staffing policy and procedure, which describes staffing and is based on benchmarking information. Staffing levels and skills mix policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery. The village manager, care centre manager and clinical nurse lead all work 40 hours per week from Monday to Friday. The village manager is available on call for any operational issues. The care centre manager and clinical nurse lead rotate the on call 24/7 duties for any clinical support or issues. The service provides 24-hour RN cover.</p> <p>At the time of the audit there were 25 of 27 residents in total (nine rest home and sixteen hospital). There is one RN and four caregivers (7.00am to 3.00pm) on duty on the morning shift, one RN and four caregivers (3.00pm to 11.00pm) on duty on the afternoon shift, and one RN and two caregivers (11.00pm to 7.00am) on duty on the night shift. A staff availability list ensures that staff sickness and vacant shifts are covered. Interviews with staff, residents and family members identified that staffing is adequate to meet the needs of residents. The team also consists of one full time diversional therapist, housekeeper,</p>

		and laundry person.
<p>Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	The resident files are electronically documented and 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 electronic record. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Electronic resident files are password protected from unauthorised access. Individual resident files demonstrated service integration.
<p>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.</p>	FA	All residents have a needs assessment completed prior to entry that identifies the level of care required. The care centre manager screens all potential enquiries to ensure the service can meet the required level of care and specific needs of the resident. Residents and relatives interviewed stated that they received sufficient information on admission, and discussion was held regarding the admission agreement. The admission agreement reviewed aligns with the ARRC contract.
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	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>Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	There are medicine management policies and procedures that align with recognised standards and guidelines for safe medicine management practice in accordance with the standards and legislation. Registered nurses and senior caregivers are responsible for the administration of medications for care residents. Senior

		<p>caregivers' complete competencies for checking and witnessing of medications as required and medication administration competency. Medication competencies and education is completed annually. All medications (robotic rolls) delivered were evidenced to be checked on delivery with any discrepancies fed back to the supplying pharmacy. The service has an electronic medication system.</p> <p>Twelve resident medication charts on the electronic medication system were reviewed. The charts had photograph identification and allergy status recorded. Indications for use were documented in all charts reviewed. All 'as required' medications had an indication for use, and efficacy was documented. The GP had reviewed the medication chart three monthly. There were no residents self-medicating on the day of audit. All medications were stored appropriately and safely in the treatment room which along with the medication fridge had the temperature taken daily which was kept in line with requirements. All eye drops were dated on opening and there were no expired drugs on site.</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>	<p>FA</p>	<p>Summerset in the Vines has comprehensive nutritional management policies and procedures for the provision of food services for residents. At present the service has a contractor for the provision of all meals on-site, (shortly the meal service will become 'inhouse' with a number of the current contracted staff remaining in their positions). The kitchen is adjacent to the dining room. Meals are served from the bain-marie to residents in the dining room for residents from one wing and under covid separation the residents from the other wing currently have a separate lounge area set up as a dining room. Meals can be delivered to residents who prefer to remain in their room. The food control plan expires on 18 September 2022. As part of the food safety programme, kitchen fridge/freezer temperatures and food temperatures are recorded and documented at the beginning of the service and when the last meal is served.</p> <p>Food safety training for food services staff has been completed. The seasonal, four weekly menu has been reviewed by a dietitian. The menu includes the resident preferences and resident dietary requirements. Dislikes are known and accommodated. Special diets</p>

		such as gluten free, soft diet, pureed meals, high calorie diet and diabetic diet are provided. The service also has an onsite café which is run by the same contractor. Residents and families can purchase meals from the café. The cook manager receives feedback from resident meetings, surveys and welcomes suggestions on the meal service. Residents and family members interviewed commented positively about the food services.
Standard 1.3.2: Declining 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.	FA	The reason for declining service entry to potential residents should this occur is communicated to the potential resident or family/whānau and they are referred to the original referral agent for further information.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	The initial support plan is developed with information from the initial assessment and the interRAI home care assessments. A suite of assessments are available to be utilised on the electronic system. 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.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	InterRAI assessments and care planning were completed within required timeframes. residents' care plans describe the individual support and interventions required to meet the resident goals and identified risks and needs. The long-term care plans reflect the outcomes of risk assessment tools and the interRAI assessments. Care plans demonstrate service integration and include input from allied health practitioners. Interventions in the care plans reviewed were current and reflective of resident's individual needs and preferences. Short-term care plans were in use 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

		<p>resident/family involvement in the care planning process. Residents/families interviewed confirmed they participate in the care planning process.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>The GP highly praised the nursing team and stated that he receives timely referrals and required follow-ups are completed in a timely manner. When a resident's condition changes, the RN initiates a review and if required a GP consultation. Relatives interviewed stated their relative's needs are met and they are kept informed of any health changes.</p> <p>There was documented evidence in the resident's progress notes of family notification of any changes to health, including infections, accidents/incidents, medication changes, GP visits and family meetings. Residents interviewed stated their needs are being met. Care plan interventions were comprehensive and included current assessed support needs. Monitoring forms are completed on the electronic resident system. Work logs entered onto the system alert staff of monitoring requirements and these are signed off as completed. Registered nurses review the monitoring charts, which include (but not limited to); pain monitoring, neurological observations, bowel monitoring, two hourly re-positioning, restraint/enablers monitoring and food and fluid intake monitoring.</p> <p>Adequate dressing supplies were sighted. Electronic wound charts, (including photographs) were in place for three residents with wounds (one resident with one skin tear, one with three skin tears and one resident with a stage 2 pressure injury). Wound assessments were completed, wound care plans were implemented, and evaluations were documented for each wound. There was evidence of wound nurse specialist involvement. Registered nurses and caregivers received training around wound care and skin care. 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>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>CI</p>	<p>The service employs a diversional therapist. She works 31 hours per week, Sunday to Thursday and leaves planned activities to be led by care staff for the other two days. The diversional therapist teleconferences with other Summerset recreational therapists. The organisational programme is prepared a month in advance to include set activities which are meaningful and relevant for all residents. Activities include (but are not limited to); exercises, church groups (as restrictions allows), music videos, news and views, group games, quizzes, and movies. There are set activities over the weekends which cover spiritual, social, sensual, and physical needs. There are spaces in the planner for the DT to arrange local activities.</p> <p>At present under covid restrictions activities are held separately for the residents of each care wing. Participation of residents is monitored and documented. Progress notes are written at least monthly and if there is any change. At present under covid restrictions some activities have been curtailed e.g. community outings, visiting entertainers and pet therapy. Group activities reflect ordinary patterns of life. All residents in the facility may choose to attend any of the activities offered.</p> <p>Daily contact is made, and one-on-one time is spent with residents who are unable to participate in group activities or choose not to be involved in the activity programme. The activity plans reviewed were well documented and reflected the resident's preferred activities and interests. Each resident has an individual activities assessment on admission and from this information, an individual activity care plan is developed. The activities plans were reviewed six-monthly and aligns with care plan evaluations. Residents and families interviewed stated they enjoy the variety of activities offered and they have input into planning of the programme via daily feedback, resident surveys and at resident meetings. The service has exceeded the standard with the introduction of Summerset FM radio station.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a</p>	<p>FA</p>	<p>All initial care plans were evaluated by the RNs and the long-term care plans were based on outcomes of these evaluations. There is evidence of resident and family involvement in the evaluation of the</p>

comprehensive and timely manner.		initial care plan and six-monthly care plan evaluations (all undertaken within required timeframe). Multidisciplinary team reviews have input into the written evaluations, which document whether the resident goals have been met or unmet. The GP completes three monthly reviews.
<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	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 residents' electronic records. The service provided examples of where a resident's condition had changed, and the resident was reassessed for a higher level of care.
<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	There are documented policies and procedures for waste disposal and chemical storage. There is a locked cleaner's cupboard and two separate locked sluice rooms. Waste management is part of the environment and equipment audit, which is conducted as part of the quality management programme. During induction, all staff are required to complete training regarding the management of waste. Chemical safety training is a component of the compulsory two yearly training and orientation training. Gloves, aprons, and goggles are available in the sluice rooms and in the laundry.
<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	The building has a current building warrant of fitness that expires on 26 February 2022. There is a full-time property manager and a part time maintenance person who undertakes property management and gardening services. There are also a number of contractors who provide maintenance services. Planned and reactive maintenance systems are in place and maintenance requests are generated through the Sway (Somerset way) on-line system (property services requests). All electrical equipment has been tested and tagged. Clinical equipment has had functional checks/calibration annually. Hot water temperatures have been tested and recorded and modifications made if required. The corridors are wide and have safety rails and

		<p>promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained. All outdoor areas have seating and shade.</p> <p>There is safe access to all communal areas. Caregivers interviewed stated they have adequate equipment to safely deliver care for rest home and hospital level of care residents. One of the three care wings remains closed following the fire whilst refurbishments continue.</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>Toilet and shower facilities are of an appropriate design to meet the needs of the residents. The fixtures, fittings, floors, and wall surfaces are constructed from materials that can be easily cleaned. All bedrooms have a hand basin or ensuite. There are adequate numbers of communal toilets and showers. Communal toilet/shower facilities have a system that indicates if it is engaged or vacant.</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 mobility aids and transferring equipment such as a hoist, as needed for cares and transfer of residents. The doors are wide enough for ambulance trolley access. Residents and families are encouraged to personalise their rooms 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 a large main lounge and dining room. There are two wings in use and each of them has separate sitting areas which are open to outdoor areas. There is also an activities room and other sitting areas. The communal areas and outdoors are easily accessible for residents who require a mobility device.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and</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. The laundry has defined</p>

<p>laundry services appropriate to the setting in which the service is being provided.</p>		<p>clean/dirty areas and an entry and exit door. The service employs two staff who undertake laundry and cleaning services each day.</p> <p>Cleaning trolleys sighted were well equipped and are kept in designated locked cupboards when not in use. Effectiveness of laundry and cleaning processes are monitored. Material safety datasheets are available and displayed in the cleaning cupboards, laundry, and sluice rooms. The housekeeper interviewed was knowledgeable around infection control practices.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>There is an emergency management and civil defence plan (2022) in place to guide staff in managing emergencies and disasters. Emergency equipment is available at the facility. A fire evacuation plan is in place that has been approved by the New Zealand Fire Service, dated 10 July 2000. Fire safety and emergency management training is provided to staff. There is appropriate equipment to respond to a fire and other clinical emergencies. Equipment was maintained by the external contractors. There is at least one staff on duty who has a current first aid certificate. Fire evacuation drills have been conducted six-monthly with the last fire drill occurring on 23 January 2022. A generator is able to be accessed from Summerset in the Bay (located in Napier) if necessary.</p> <p>Civil defence and pandemic/outbreak supplies are available and are checked regularly. Staff emergency and disaster management training is provided to staff. There is sufficient water stored (two water tanks holding 2,500 litres) to ensure ten litres per resident for three days. Alternative heating and cooking facilities (two BBQ's and gas bottles) are available in the event of a power failure. There is emergency back-up lighting available for up to four hours. Smoke alarms, sprinkler system and exit signs are in place. The tour of the facility, residents were observed to have easy access to the call bells, and residents interviewed stated their bells were answered in a timely manner. Call bell audits are carried out monthly. The facility is secured at night.</p> <p>On 25 September 2021 a fire event occurred in the Merlot wing, the fire brigade attended and managed to contain the spread of the fire.</p>

		Care staff evacuated residents from the wing and no injuries were sustained by either residents or staff. It was deemed that the Merlot wing was no longer suitable for resident tenure, due to fire, smoke and water damage and was temporarily closed (link 1.2.1). All residents that were residing within the Merlot wing were appropriately relocated through consultation with the resident and/or their EPOA to another care room, facility location or ARRC provider. Two staff affected by the Merlot wing closure were also temporarily transferred to another facility (Summerset Palms, Te Awa).
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	Visual inspection shows 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.
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	There are comprehensive organisational infection control policies. There is an organisational infection control programme in place which is reviewed annually by the team at head office. The infection prevention and control coordinator is an RN supported by the care centre manager and the infection control committee. Quality improvement and staff meetings include infection control data and surveillance activities. There is a monthly benchmarking of infections conducted for all Summerset facilities. There are clear lines of accountability to report to the infection control committee on any infection control issues including a reporting and notification of infections. Since Covid 19 there have been a number of changes to infection control activities. At present a full electronic sign is required for all visitors (two visitors per hour are permitted in the facility) and the care facility has been divided into two – so dividing the residents and care staff into two to minimise the impact of an outbreak.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to	FA	The infection control committee comprises of a cross section of staff from areas of the service. The infection control committee meetings

<p>implement the infection control programme and meet the needs of the organisation.</p>		<p>occur monthly. The facility has access to an infection control nurse specialist at the DHB, public health authorities, laboratory, GPs, and experts within the organisation. Infection events are forwarded to head office for benchmarking.</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 reflect the Infection Control Standard SNZ HB 8134:2008, legislation and good practice. The infection control policies link to other documentation and cross reference where appropriate. Policies, procedures, and the pandemic plan have been updated to reflect current covid guidelines and recommendations.</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 prevention and control coordinator and the care centre manager are responsible for coordinating and providing education and training to staff. Ongoing training occurs annually as part of the training calendar and resident education occurs as part of providing daily cares. Care plans included infection prevention and control interventions as appropriate. Staff have received additional training related to infection control and prevention, hand hygiene and outbreak management since the event of covid. A focus has been placed on infection prevention and control over the year. This education has been delivered by head office staff and onsite including at handovers. Additional education has included videos. The DHB IC nurse specialist has undertaken training of the staff including the donning and doffing of personal protective equipment six monthly.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>CI</p>	<p>There is a policy describing surveillance methodology for monitoring of infections. The surveillance programme is implemented and is appropriate to the size and complexity of the facility. Infection events are entered into the electronic patient management system and extracted monthly onto the electronic system. The infection prevention and control coordinator provides infection control data, trends and relevant information to the infection control committee and clinical/quality meetings. There have been two outbreaks since the</p>

		<p>previous audit, both were well managed, documented, and the public health team were notified in a timely manner.</p> <p>The service has exceeded the standard in reducing urinary infections.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The restraint policy includes the definitions of restraint and enablers, which is congruent with definitions in NZS 8134.0. The policy includes comprehensive restraint procedures. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. The restraint standards are being implemented and are reviewed. Interviews with staff confirm their understanding of restraints and enablers. Restraint minimisation training is part of the annual training programme along with restraint competency.</p> <p>Enablers are assessed as required for maintaining safety and independence and are used voluntarily by residents. On the day of audit, the service had one resident using two restraints (low bed and lap belt) and two residents using an enabler (bedsides).</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>An experienced RN is the restraint coordinator. Assessment and approval process for restraint use includes the clinical nurse lead, RNs, and GP. The restraint coordinator has a signed position description.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>Restraint assessments are based on information in the care plan, resident discussions and on observations by the staff. There was a restraint assessment tool completed for the two residents using enablers (side rails) and the one resident on restraint (low bed and a lap belt when in chair).</p>
<p>Standard 2.2.3: Safe Restraint Use</p>	FA	<p>The service has an approval process, as part of the restraint minimisation policy that is applicable to the service. There are</p>

<p>Services use restraint safely</p>		<p>approved restraints documented in the policy. The approval process includes ensuring the environment is appropriate and safe. Assessments and care plans identify specific interventions or strategies to try (as appropriate) before restraint is used.</p> <p>The care plans of the one resident with restraint and the two with enablers identified potential risks, identified observations and monitoring. Restraint use is reviewed through the three-monthly assessment evaluations, monthly restraint meetings and six-monthly multidisciplinary meeting (input from family/EPOA is invited). A restraint/enabler register is in place which includes the resident on restraint and the two residents using an enabler.</p>
<p>Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>Evaluation has occurred three-monthly as part of the ongoing reassessment for the residents on the restraint /enabler register, and as part of their care plan review. Family input is invited as appropriate.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>CI</p>	<p>Individual approved restraint is reviewed at least monthly through the restraint meeting. Internal audits of restraint are undertaken at least six-monthly. All data is benchmarked within the organisation. The service has exceeded the standards around restraint minimisation.</p>

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	CI	<p>The achievement of the rating that service provides an environment of ongoing quality initiatives is beyond the expected full attainment. Summerset in the Vines has worked collaboratively as a team to improve the quality of care for residents in relation to falls, skin tear and bruising incident reductions. Through data trends and analysis the clinical team has actively worked at implementing best practice initiatives and training involving specialist support. There is evidence of action taken based on findings that has made improvements to service provision.</p>	<p>There are monthly accident/incident benchmarking reports completed by the care centre manager that break down the data collected across the care centre. All ongoing wounds and individual incidents are discussed to look at the whole picture including the resident’s health conditions, the current care plan, environment, staff education, staff skill mix, and quality improvement plans in place to minimise further incidents. All new incidents, and wounds are discussed to determine “why” residents are experiencing skin tears, bruising, or incidents such as falls. The care centre manager and leadership team also monitor falls very closely. Falls continue to be discussed at the quality improvement meetings, with fall prevention strategies reviewed, and the residents underlying</p>

			<p>conditions considered.</p> <p>The physiotherapist review changes in resident mobility and a lounge carer is in the lounge monitoring residents. Residents at risk of falling are encouraged to join the exercise programme. Falls and incidents are discussed at the handovers between shifts to ensure staff are up to date with current information. In RN/clinical meetings case reviews are conducted and clinical nurse specialist input from the local DHB is accessed. All care staff have completed practical assessments with the site physiotherapist to ensure they are competent in all areas in of manual handling of residents, intentional rounding and walking programmes were also introduced.</p> <p>Clinical indicator data obtained from Power BI reporting indicates the following falls, skin tears and bruising incident reductions:</p> <p>Falls reduction: from 1 February 2021 to 31 January 2022 the falls rate was 70% below the Summerset national average. Trends indicate a marked reduction in the amount of falls/1000 bed nights, for the period 1 July–30 Sept 2021 there were 14.59 falls/1,000 bed nights and for the period 1 Oct 2021–31 Jan 2022 there were 5.28 falls/1,000 bed nights – a reduction of 63.8%.</p> <p>Skin Tears reduction: from 1 July 2020 to 31 January 2022 Summerset in the Vines was consistently below the Summerset average benchmark for soft tissue injury. Trends indicate a marked reduction in the amount of skin tear incidents per 1000 bed nights from a peak of 11.05 events per 1000 bed nights in June 2020 to 1.46 per 1000 bed nights in January 2022. The monthly skin tear rates</p>
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			<p>were under the Summerset benchmark for 14 of the past 24 months.</p> <p>Bruising reduction: from 1 February 2020 to 31 January 2022 Summerset in the Vines was consistently below the Summerset average in regard to bruising incidents and for 11 months of this period no bruising incidents occurred. Bruising rates have reduced from a peak of 15.31 events per 1000 bed nights in May 2020 to 1.26 incidents per 1000 bed nights in January 2022. Summerset in the Vines bruising rates have been lower than the company average incident rate for 19 of the past 24 months. This is evidenced consistently from September 2020 onwards.</p>
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	CI	<p>Summerset FM is a project that aims to stimulate and improve resident's mood and memory as well as reduce stress and anxiety. These outcomes are achieved through music playing via the care centre's internal PA system. Summerset FM is client driven and airs weekly on a Friday afternoon during residents' social drinks/happy hour. The Summerset FM playlist reflects individual preferences and music taste. To be considered beneficial, music needs to be positive/motivating, enjoyable and familiar. For a client centred approach, residents are encouraged to place song requests directly with the Summerset FM host or indirectly with the DT (playlist document). Families can also give input on behalf of a resident via DT consultation. Having the ability to broadcast a client focussed playlist widely throughout the care centre creates a shared experience during which residents can explore memories, emotions, reminisce with each</p>	<p>Summerset FM improves resident's wellbeing and quality of life by boosting confidence, self-determination, and self-worth, along with the many benefits of music therapy. As a client centred tool it puts power back with the resident which is especially important during the pandemic when a lot of things seem beyond our control. In addition, it is an alternative when live entertainment is not possible due to covid-19 regulations or other restrictions. Summerset FM creates joy by having one's musical preferences recognised, respected, and supported. Along with the aforementioned covid restrictions, the introduction of Summerset FM also helped address no DT cover on Fridays and Saturdays due to transfer of part-time recreational therapist to sister site in Napier following the reduction in bed numbers after the fire at the facility.</p>

		other and socialise with or without a drink.	A survey conducted in February 2022 showed 100% of all residents enjoy listening to the music played on Summerset FM and 88% of residents stated that the introduction of Summerset FM has encouraged them to attend happy hour.
<p>Criterion 3.5.7</p> <p>Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>	CI	<p>Summerset in the Vines has been engaged in a HQSC project through 2021 to ensure the appropriate use of antimicrobial treatment and reduction of urinary tract infections (UTIs). This engagement included regular meetings with HQSC and other providers to review anonymous infection data and treatment decisions. From this, a user guide is being developed for use in age residential care facilities throughout NZ.</p> <p>Summerset in the Vines has been sustaining two through to 10 urinary tract infections per month through 2020. These trends were identified through benchmarking against other Summerset sites and through a review of the 2020 data graphs. These trends were discussed in detail at the site quality meetings and fed back through RN and caregiver meetings. Hydration training and hygiene cares were a focus of practice review for the RNs through 2021. A trial of the HQSC UTI decision support tool was implemented to support identification and treatment options of UTI's.</p>	<p>Urinary tract infection rates halved over the past twelve months for Summerset in the Vines. All identified potential UTI's are screened by the RN using the decision-making support tool in consultation with the resident GP, including specimen culture to ensure appropriate treatment. Data for January through to December 2020 was benchmarked against the data for January to December 2021. This highlighted that the year of 2020 evidenced 54 UTIs in comparison to 2021 evidencing 18 total infections. This shows a 66.7% reduction of UTI's comparing the two years.</p>
<p>Criterion 2.2.5.1</p> <p>Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:</p> <p>(a) The extent of restraint use and any</p>	CI	<p>Summerset in the Vines has had a strong focus on restraint minimisation in the past two years. This is evidenced by the data below, monthly restraint meetings, the purchase of new equipment, the introduction of intentional</p>	<p>The restraint data showed in January 2020 that the facility had nine forms of restraint and the team actively wanted to minimise this. Through the restraint meetings the team reviewed every resident and worked with residents, whanau,</p>

<p>trends;</p> <p>(b) The organisation's progress in reducing restraint;</p> <p>(c) Adverse outcomes;</p> <p>(d) Service provider compliance with policies and procedures;</p> <p>(e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;</p> <p>(f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;</p> <p>(g) Whether changes to policy, procedures, or guidelines are required; and</p> <p>(h) Whether there are additional education or training needs or changes required to existing education.</p>		<p>rounding on residents that have restraint applied and a focussed, results driven team.</p>	<p>and staff to educate around restraint minimisation. All the data from the restraint meetings is fed through and discussed at the monthly RN, caregiver and quality meetings allowing across the board staff input and awareness. New equipment was purchased including sensor mats, landing mats and grab rails. Changes in practice have included (but are not limited to); anytime a restraint is considered, the clinical on call person is contacted and a care intervention review is conducted to ensure that restraint application is the last resort, the introduction of intentional rounding and the walking programme</p> <p>For the year January to December 2020 the service had reduced the number of devices used for restraint to 4.5/ 1000 bed nights. This data shows there was a 55.6% reduction in the use of restraint devices.</p> <p>Restraint device use for the period January to December 2021 has further reduced to 2.00/1,000 bed nights. The reduction of restraints has not increased the overall incidence of falls in Summerset in the Vines.</p>
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End of the report.