Summerset Care Limited - Summerset on Cavendish

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 on Cavendish
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 18 January 2021 End date: 19 January 2021

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 61

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 on Cavendish is a new retirement village complex that opened on 16 March 2020. The service provides rest home, hospital and secure dementia care for up to 22 residents in the secure dementia unit, 57 dual purpose (rest home and hospital) beds in the care centre and rest home level care across 56 serviced apartments. On the day of audit there were six rest home level residents in the serviced apartments, 20 in the secure dementia unit and 35 residents in the care centre.

This certification audit was conducted against the relevant Health and Disability Services 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 care centre manager who has been in the role since October 2020. The care centre manager is supported by a clinical nurse leader who has been in the position since November 2020. There is also an overall village manager. 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.

This audit identified improvements required related to, open disclosure, timeframes, care plan documentation, activity plans and hot water temperatures.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Some standards applicable to this service partially attained and of low risk.

The facility provides care in a way that focuses on the individual resident. There is a Māori health plan and cultural safety policy supporting practice. Cultural assessments are undertaken on admission and during the review process. The service functions in a way that complies with the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and related services is readily available to residents and families. Policies are available that support residents' rights. Residents and where appropriate their family/whānau are being provided with appropriate information to assist them to make informed choices and give informed consent. Care plans accommodate the choices of residents and/or their family. Complaints processes are being implemented and complaints and concerns are managed and documented. Residents and family interviewed verified ongoing involvement with community.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.

Summerset on Cavendish has a documented quality and risk management system. Key components of the quality management system link 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. There are human resources policies including recruitment, selection, orientation and staff training and

development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care. There is a staffing policy in place.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

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 recreational 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 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 facility has a large workable kitchen in a service area situated on the ground floor. The menu is designed and reviewed by a registered dietitian. Food is transported in hotboxes to each area. Nutritional profiles are completed on admission and provided to the kitchen. There is a café on site.

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

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 CPU. Resident bedrooms are spacious and personalised. All resident rooms have ensuites, and access to communal toilets/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 are spacious and accessible. The outdoor areas are 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

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.

The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. There were no residents with any restraints or enablers at the time of the audit. Staff receive training around restraint minimisation and management of challenging behaviours.

Infection prevention and control

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

The infection control programme is appropriate for the size and complexity of the service. 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. 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. A 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 Summerset facilities.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	40	0	4	1	0	0
Criteria	0	88	0	4	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 Health and Disability Commissioner's (HDC) Code of Health and Disability Consumers' Rights (the Code) brochures are accessible to residents and their families. Policy relating to the Code is implemented and 16 staff interviewed (five caregivers, one clinical nurse lead, two registered nurses (RN), one diversional therapist, one property manager, four managers, one housekeeper and one laundry staff) 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.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	The service has in place a policy for informed consent. Completed resuscitation and general consent forms were evident on all eight resident files reviewed (two rest home- including one serviced apartment resident, three hospital including one respite and three dementia). Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for entering rooms and personal care. Enduring power of attorney (EPOA) evidence is filed in the residents' charts. All residents in the dementia unit have activated EPOAs.

Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	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.
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	The service has an open visiting policy. Residents may have visitors of their choice at any time and family interviewed confirmed that they can visit whenever they like. The main doors lock automatically at dusk and independent residents hold a swipe card to enter the building after doors are locked. The service encourages the residents to maintain their relationships with their friends and community groups. Assistance is provided by the care staff to ensure that the residents participate in as much as they can safely and desire to do as observed during the audit.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The organisational complaints policy states that the village manager has overall responsibility for ensuring all complaints (verbal or written) are fully documented and investigated. The care centre manager is responsible at this facility for addressing any complaints in consultation with the village manager. A complaints procedure is provided to residents within the information pack at entry. Feedback forms are available for residents/family members in various places around the facility. There is a complaints' register that includes relevant information regarding the complaint. There have been four formal complaints lodged since the service opened in March 2020. The complaints were reviewed, and this confirmed that complaints are responded to in a timely manner as per policy. Residents and family interviewed stated that they felt they could complain at any time and those that had, stated that their concerns had been dealt with in a timely manner to their satisfaction. They also stated that the new managers were 'extremely competent and visible' which allowed for discussion and encouraged any concerns to be raised.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	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. On admission an RN discusses aspects of the Code with residents and their family on admission. Discussions relating to the Code are also held during the monthly resident and three-monthly family meetings. Nine residents interviewed (five rest home including one in the serviced apartments and four requiring hospital level care) confirmed that they received cares that met their needs, and all were aware of their rights.

		Three family members interviewed (one hospital and two dementia level care) 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	Guidelines on abuse and neglect are documented in policy. Staff receive annual education and training on abuse and neglect, which begins during their induction to the service. Staff, the general practitioner and two external providers interviewed confirmed that there was no evidence of abuse or neglect. There are spiritual services and residents are encouraged to attend their own spiritual care in the community. Any resident or family member can attend. Spiritual needs are individually identified as part of the assessment and care planning process. 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. All the residents and families interviewed confirmed that residents' privacy is respected.
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	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. The care staff interviewed reported that they value and encourage active participation and input from the family/whānau in the day-to-day care of the resident. At the time of the audit there was one resident living at the facility who identified as Māori and was assessed for cultural needs with any plans documented in the care plan. Māori consultation is available through links with Māori organisations including Te Wananga O Aoteroa, who can provide advice and support if required. Staff receive annual education on cultural awareness that begins during their induction to the service.
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	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. Beliefs and values are discussed and incorporated into the care plan as sighted in the review of eight resident records. Residents and families interviewed confirmed they are involved in developing the resident's plan of care, which includes the identification of individual values and beliefs.
Standard 1.1.7: Discrimination	FA	There are implemented policies and procedures to protect clients from abuse, including discrimination,

Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.		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 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 stated 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, hospital and dementia level care as identified 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 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 stated that they are supported by the management team. Caregivers complete competencies relevant to their practice. The general practitioner interviewed is satisfied with the care that is being provided by the service.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	PA Low	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. A review of 15 incident forms confirmed that family were not always informed when incidents occurred. However, family interviewed confirmed they were informed at all times. Resident meetings occur monthly and family meetings are three-monthly. Residents and family confirmed that they find the meetings useful and provide opportunities to raise issues or concerns. Residents and family interviewed confirmed that the village manager, care centre manager, clinical nurse lead and the village manager have an open-door policy. The regional quality manager interviewed also stated that the managers discuss how they can improve resident outcomes on a regular basis. 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).
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Summerset on Cavendish is a new retirement village complex that opened on 16 March 2020. The care centre is a three-level facility. There are 43 (rest home and hospital level) rooms on the first floor (all dual-purpose) including 14 double room available for couples, which allows for a total of 57 residents. There are 20 rooms in the dementia unit (all certified as suitable to have couples, but the service would only take up to two couples at a time making 22 total beds in the memory care unit. There are 56 serviced apartments across three floors, and all are certified as suitable to provide rest home level care. At the time of audit there were 61 residents in total, 18 rest home residents, 17 hospital level residents, 20 dementia care residents, including one resident on respite care and six rest home level of care residents in the serviced apartments. The service has a village manager who has been in the role for the last two years and has a background in retirement village management, aged care and business management. A care centre manager was appointed in October 2020 and supports the village manager. The care home manager is a registered nurse and has many years' aged care, dementia care and clinical management experience. A regional clinical manager and quality improvement manager also support the managers (both were present at the time of the audit). Summerset Group has a well-established organisational structure, which includes a board, chief executive officer, operations managers, and a national clinical improvement manager. Each of the Summerset facilities throughout New Zealand is supported by this structure. The Summerset group has a comprehensive suite of policies and procedures, which will guide staff in the provision of care and services. Summerset Group have a quality assurance and risk management programme and an operational business plan for the project. Quality objectives and quality initiatives are set annually. There is a village manager and care home manager's job description that includes authority, accountability and responsibility including reporting requirements.
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and	FA	A roving Summerset village manager will fulfil the village manager's role during a temporary absence otherwise the care centre manager will fulfil the village manager's role with support from the national clinical improvement manager and the regional manager. The organisation completes annual planning and has comprehensive policies/procedures to provide rest home, hospital (geriatric and medical) and dementia level care.

effective manner which ensures the provision of timely, appropriate, and safe services to consumers.		
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.	FA	The service is implementing the 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 at an organisation level. The content of policy and procedures are detailed to allow effective implementation by staff. The Summerset group has a quality assurance framework 2021 calendar. The calendar schedules the training, meetings, and audit requirements for the month. The annual residents/relatives survey for the service was completed in October 2020, with an overall satisfaction of 98.5%. There is a meeting schedule that includes monthly meetings as follows: quality improvement; caregiver; registered nurse; activities; and resident meetings. There are three-monthly family meetings. There is a monthly care staff meeting that includes discussion about clinical indicators (eg, incident trends, infection rates). Health and safety, infection control and restraint meetings have occurred monthly. There is also a weekly management meeting. 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, hospital and dementia level care 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. Summerset's clinical and quality managers analyse data collected via the monthly reports and corrective actions are required based on benchmarking outcomes. 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, sharing of health and safety information and actively encourage staff input and feedback. The service ensures that all new staff and any contractors are inducted to the health and safety programme with a health and safety competency completed by staff as part of orientation (staff records confirmed that these had been completed). Falls prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. A quality improvement project was implemented in November 2020 around decreasing the amount of category A events out of the dementia care unit (Memory Care) by focusing on improving the team's knowledge on dementia to

		empower them with the tools to ensure events are decreased over the next six months. This is to achieve a safe environment for the residents and the members working in Memory Care.
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.	FA	The incident reporting policy includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Incident and accident data is being collected and analysed. A review of fifteen accident/incident forms that occurred in January 2021 document timely RN review and follow-up. However neurological observations were not completed for six of twelve unwitnessed falls with a potential head injury (link 1.3.6.1). Six of the fifteen forms reviewed did not have documented evidence that family had been notified of incidents/accidents (link 1.1.9.1). Data is linked to the organisation's benchmarking programme and used for comparative purposes. Discussions with the management team confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Section 31 notifications are completed as required, there has been seven Section 31 notifications completed around four residents with challenging behaviours. Notification had also been completed for the new care centre manager who started in October 2020.
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. Nine staff files (one care centre manager, one clinical nurse lead, one registered nurse, four caregivers, one recreational therapist and one property manager) were reviewed and all had relevant documentation relating to employment. 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 were orientated well to the service. The orientation programme includes a buddy system with the new staff member working alongside an experienced care staff member for five days. There is an annual education plan in place. The 2021 education plan is being implemented and staff stated that this is relevant to their role. A competency programme is in place with different requirements according to work type (eg, 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 in total (including three casual), three RNs and the clinical lead are trained in interRAI. There are 33 caregivers in total. Caregivers have completed Careerforce training as follows: fifteen have completed level four; ten have completed level three and six have completed level two training. Eighteen caregivers work in the dementia unit, 13 of

		18 caregivers have completed their dementia standards. Five caregivers are in the process of completing their dementia standards.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	Human resource policies include documented rationale for determining staffing levels and skill mixes for safe service delivery (Safe staffing policy). This defines staffing ratios to residents and rosters have been developed and are adjustable depending on resident numbers. The village manager and care centre manager both work full time Monday to Friday and are on call 24/7 for any operational and clinical issues respectively. They are supported by a clinical nurse lead in the rest home/hospital and dementia units. At the time of the audit the service were making responsibility changes to the dementia care unit clinical nurse lead role to meet the required expectations for the role. Interviews with five caregivers (three hospital/rest home, one dementia care and one serviced apartments) stated the RNs are supportive and approachable. Interviews with residents and relatives indicated there were sufficient staff to meet resident needs. Staffing at Summerset on Cavendish is as follows; in the rest home/hospital unit (43 beds) there were 18 rest home and 17 hospital residents. There is a clinical nurse lead/RN who is supported by one RN on the morning shift, afternoon shift and night shift. There are six caregivers (four full and two short-shifts) on the morning, five caregivers (three full and two short-shifts) afternoon shifts and three caregivers on night shift. In the dementia care unit (22 beds) there were 20 residents. There is a memory care lead (qualified social worker) who is supported by one RN on the morning shift. There are three caregivers (two full and one short-shifts) on the morning, three caregivers (two full and one short-shifts) afternoon shifts and two caregivers on night shift. In the serviced apartments there are six rest home level residents, there is one caregiver on the morning shift and one caregiver on the afternoon shift. A caregiver from the rest home/hospital unit covers the serviced apartments on the night shift.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The residents' files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24-hours of entry into each resident's individual record. An initial support plan is also developed in this time. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access by being held in a secure room. Entries are legible, dated, timed, and signed by the relevant caregiver or nurse, including designation. Residents' electronic files are protected from unauthorised access by individual passwords.

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	All residents have a needs assessment completed prior to entry that identifies the level of care required as evidenced in two rest home, three hospital and three dementia level resident files reviewed. 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, including ringing the referring service a day prior to admission. 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 (a) – (k) of the ARRC contract. The three dementia resident files also included an occupation rights agreement (ORA).
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	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.
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.	FA	There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. Registered nurses and senior caregivers have completed annual medication competencies and education. Registered nurses have completed syringe driver training. Medications are stored safely in all units. All regular medications (roll packs) are checked on delivery by RNs against the electronic medication chart. A bulk supply order is maintained for hospital level residents. All medications were within the expiry dates. Eyedrops and ointments are dated on opening. The medication fridges and rooms are checked weekly and temperatures sighted were within the acceptable range. There was one resident self-medicating on the day of audit. Medications were stored safely in the resident's room. Three monthly self-medication competencies had been completed by the RN and authorised by the GP. There were no standing orders. There were no vaccines stored on site. Sixteen medication charts on the electronic medication system were reviewed from across rest home, hospital and dementia level care. Medications are reviewed at least three-monthly by the GP. The GP and the community mental health nurse review medications for dementia care residents. There was photo identification and allergy status recorded. 'As required' medications had indications for use prescribed. The effectiveness of 'as required' medications is recorded in the progress notes and on the electronic medication system. Medication administration observed complied with policy.

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	Summerset has comprehensive nutritional management policies and procedures for the provision of food services for residents. Summerset on Cavendish employs the kitchen staff (a change from Summerset overall policy of contracted services). Meals are delivered to units in scan boxes and are served from the bain marie to residents in the dining rooms by the chef or kitchen staff. Meals can be delivered to residents who prefer to remain in their room. The food control plan expires March 2021. 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. Food safety training for food services staff has been completed. The seasonal menu has been reviewed by a dietitian. The menu includes the resident preferences and resident dietary requirements. Dislikes are known and accommodated. Special diets 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 chef 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. Clinical risk assessments are completed on admission where applicable and reviewed six-monthly as part of the interRAI assessment. Outcomes of risk assessment tools are used to identify the needs, supports and interventions required to meet resident goals. The GP complimented the clinical team on their improving assessment skills. The service employs seven RNs and a clinical nurse lead and four are interRAI competent.
Standard 1.3.5: Planning	FA	Care plans reviewed evidenced multidisciplinary involvement in the care of the resident and all

Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.		resident care plans were up to date. All care plans reviewed were resident centred, however not all interventions to support resident assessed needs were documented (link 1.3.6.1). The service has implemented a continuing education process for staff around the electronic care planning system. There was a behaviour management plan in the files of dementia care residents that included interventions and strategies for de-escalation including activities. All care plans reviewed had been updated when there were changes to health, risk, infections or monitoring requirements. Residents and relatives interviewed stated that they were involved in the care planning process with the RNs. There was evidence of service integration with documented input from a range of specialist care professionals including the physiotherapist, hospice nurse, dietitian, district nurse, wound care nurse and mental health services for older people. The care staff interviewed advised that the care plans were easy to access and follow.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Moderate	The general practitioner praised the clinical improvements and noted that the new clinical nurse leader and leadership team had made impressive changes. The GP visits the service at least twice weekly and more often if required. When a resident's condition changes, the RN initiates a review and if required a GP or nurse specialist consultation. Relatives interviewed stated their relative's needs are met and they are kept informed of any health changes (link 1.1.9.1). Care plans reviewed evidenced multidisciplinary involvement in the care of the resident and all resident care plans were up to date. All care plans reviewed were resident centred, however not all interventions to support resident assessed needs were documented. 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. 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 pain monitoring, neurological observations, bowel monitoring, two hourly re-positioning, restraint/enablers monitoring and food and fluid intake monitoring. However, neurological observations were not completed for six unwitnessed falls with a potential head injury. Adequate dressing supplies were sighted. Initial wound assessments with ongoing wound evaluations and treatment plans were in place for nine residents with wounds, eight skin tears and one chronic wound. There were no residents with a pressure injury. Wound assessments were completed, and wound care plans were implemented. RNs 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. There are a number of monitoring

		forms available for use.
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.	PA Low	The service employs a diversional therapist who works six days a week and works in the rest home/hospital unit. The dementia care unit lead and a part time activities person lead the activities in the dementia unit. The diversional therapist teleconferences with other Summerset recreational therapists on a regular basis. The activities programme for the dementia unit and the hospital/rest home programme is prepared a month in advance and are meaningful and relevant for all residents. Rest home and hospital residents join together for the activity programme. Participation of residents is monitored and documented. There are strong links with the community. Group activities reflect ordinary patterns of life and include at least weekly planned visits to the community. 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. There are regular van outings for residents (as appropriate), regular entertainment and involvement in the community. 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. Activity plans for the residents in the dementia unit are resident centred and comprehensive for the daytime. They do not all cover a 24-hour period. 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.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	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 initial care plan and six-monthly care plan evaluations. Multidisciplinary team reviews have input into the written evaluations, which document whether the resident goals have been met or unmet. The general practitioner completes one to three-monthly reviews.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or	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, geriatrician, mental health services for older people and dietitian. Discussion with the registered nurses identified that the service has access to a wide range of support either through the

referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.		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 policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas. Safety data sheets and product sheets are available. Sharps containers are available and meet the hazardous substances regulations for containers. The hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff. A spills kit is available.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Low	The building holds a CPU; a building warrant of fitness was in the process at the time of reports as the CPU expires 1 February 2021. There is a full-time property manager. Contractors are available when required. Electrical equipment has been tested and tagged. The hoists and scales are new and are scheduled for annual checks. Hot water temperatures have been monitored but not in resident areas. The care centre building is a three-story building. The ground floor includes nine serviced care apartments, service areas and a secure dementia unit (Memory Care unit). The Memory Care unit are all LTO apartments. All of the apartments in the Memory Care unit are suitable for couples if required. Level one includes 43 rooms (all dual-purpose hospital/rest home rooms). There are 14 double rooms suitable for couples. The ground floor Memory Care unit and the first-floor dual-purpose unit is built around a large, landscaped courtyard. The secure courtyard is well designed/landscaped for wandering and includes raised planters and seating and umbrellas for shade. The courtyard is on the ground floor and is accessible for the residents in the Memory Care unit and can be easily observed by the residents in the care centre. The previous audit noted that the service will need to consider how the privacy of the residents in the memory care unit garden will be protected, strategies have been implemented around this. In the dual-purpose rooms on level one there are large spacious corridors. All resident rooms include electric beds and appropriate mattresses for pressure relief. There are two lifts between floors, one is large enough for a bed/stretcher if needed. There are two stairwells at either end of the building.

		Residents are able to bring their own possessions into the home and are able to adorn their room as desired. The maintenance schedule includes checking of equipment. All rooms and communal areas allow for safe use of mobility equipment. There is adequate space for storage of mobility equipment in each of three floors. External landscaping is completed with a number of areas for residents. Caregivers interviewed stated they have adequate equipment to safely deliver care for rest home, hospital and dementia level of care residents
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	There are adequate numbers of toilets and showers with access to a hand basin and paper towels. All resident rooms across the facility have a single mobility ensuite with shower and toilet. There are mobility toilets located near all lounges with locks that can be opened from the outside if needed. There are separate staff and visitor toilets. There are picture signs for residents in the Memory Care unit to assist with locating the toilet.
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	Residents rooms are spacious and allow care to be provided and for the safe use and manoeuvring of mobility aids. Mobility aids can be managed in ensuite and communal toilets and bathrooms. Double rooms are large enough for two beds and mobility equipment. The apartments in the Memory Care unit and the serviced apartments all have a separate lounge and bedroom.
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	There is a café, dining room and large lounge area adjacent to the apartments on the ground floor. This is available for village residents, visitors and any care centre residents that choose to go to the café. There is also another lounge/dining area for serviced apartment rest home residents on level one. There is a separate dining room and kitchenette on one side of the Memory Care unit. On the other side of the Memory Care unit there is a spacious activity room and lounge. There is also a separate family room and sensory room off the lounge. On level one (dual-purpose unit), there is a large spacious living area and kitchenette/dining area. There is a separate recreation area off the lounge. There is also a large spacious conservatory area

		and covered balcony. A separate family room is also available. There are other areas available for sitting and resting.
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	There are policies for cleaning and infection prevention and linen handling and processing. These policies ensure that all cleaning and laundry services are maintained and functional at all times. The laundry is in the service area on the ground floor and has an entrance for dirty laundry and an exit for clean. The laundry is large and includes two commercial washing machines and two dryers. Dirty linen can be transported to the ground floor via a laundry chute in the laundry. Linen trolleys have been purchased. Care staff will initially manage laundry. Laundry staff will be employed as resident numbers increase. There are documented systems for monitoring the effectiveness and compliance with the service policies and procedures. Laundry and cleaning audits are to be commenced as per the quality assurance programme.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	There are emergency and disaster manuals to guide staff in managing emergencies and disasters. Emergency management, first aid and CPR are included in the mandatory in-service programme. There is a minimum of one first aid trained staff member on every shift. The care centre has an approved fire evacuation plan and fire drills six monthly. Smoke alarms, sprinkler system and exit signs are in place. The service has emergency generators on site that are serviced by an external contractor. Emergency lighting is in place, which will last for four hours. There are civil defence kits in each unit and adequate stores of drinkable and non-drinkable water on site. There is a separate entrance area into the Memory Care unit. Visitors have speaker access to staff and then the door will be released to enter the entrance foyer. There is a glass panelled door from the foyer unit the unit that can also be opened by staff for visitors to enter. All exits in and out require swipe card access by staff. There is a main double-door entrance into the care centre that will be secure at dusk with phone access.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with	FA	General living areas and resident rooms are appropriately heated and ventilated. Resident's rooms throughout the facility have air conditioning units. The communal living areas are heated and cooled via ceiling heating/cooling systems. All rooms have external windows with plenty of natural sunlight. All windows are double-glazed, and all areas have good lighting. In the Memory Care unit rooms,

adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.		individual resident room lighting can be controlled by staff from controls outside each room. Some rooms in the care centre have Juliet balconies.
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 infection control policies, a 2021 infection control plan that includes a review of 2020 infection control. 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. All staff complete infection control education on orientation and annually as part of the education planner.
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 committee comprises of a cross section of staff from areas of the service. The infection control committee meetings have been meeting throughout 2020 at least monthly. Infection control data is reported and discussed at monthly RN meetings. The facility has access to an infection control nurse specialist at the DHB, public health authorities, laboratory, general practitioners and experts within the organisation. Infection events are forwarded to head office for benchmarking. The infection control nurse is an active member of the Summerset Infection control group. Summerset on Cavendish have implemented the Summerset Covid-19 plans including tracking and tracing. There are plentiful supplies of PPE.
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	FA	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.

appropriate/suitable for the type of service provided.		
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection 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 received training related to infection control and prevention, hand hygiene and outbreak management as part of annual training and on orientation to the service.
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	There is a policy describing surveillance methodology for monitoring of infections. A 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 share point electronic system. The infection prevention and control coordinator provide infection control data, trends and relevant information to the infection control committee and clinical/quality and RN meetings.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. The facility has been restraint-free since opening in March 2020. All incidents of behaviours that challenge are discussed in meetings. Alternatives are determined to avoid the use of restraint. Residents can voluntarily request and consent to enabler use. Staff training is provided around restraint minimisation and management of challenging behaviours on an annual basis.

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 1.1.9.1 Consumers have a right to full and frank information and open disclosure from service providers.	PA Low	A review of 15 incident forms confirmed that family were not always informed when incidents occurred. However, family interviewed confirmed they were informed at all times	Six of the fifteen forms reviewed did not have documented evidence that family had been notified of the incident/accident	Ensure documentation reflects that family are informed of adverse events. 90 days
Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review,	PA Low	Eight resident records were reviewed (two rest home, three dementia and three hospital). All initial assessments and care plans were completed within 24 hours of entry to the service. InterRAI assessments were also not always completed within 21 days of entry to the service. Six monthly interRAI assessments were completed in a timely manner. The service has recognised the issue and an action plan has been	Two hospital level, one dementia care level and one rest home level first interRAI and long-term care plans were not within timeframes.	Ensure that interRAI assessments and care plans are completed within required timeframes.

and exit) is provided within time frames that safely meet the needs of the consumer.		implemented.		90 days
Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Moderate	Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans reviewed were resident centred, however not all interventions to support resident assessed needs were documented. The service has implemented a continuing education process for staff around the electronic care planning system. Registered nurses review the monitoring charts, which include pain monitoring, neurological observations, bowel monitoring, two hourly re-positioning, restraint/enablers monitoring and food and fluid intake monitoring. However, neurological observations were not completed for six unwitnessed falls with a potential head injury.	(i). Neurological observations were not completed for six unwitnessed falls with a potential head injury. (ii) One hospital level resident care plan did not include interventions for: skin care and an ileostomy, interventions for a red sacrum, a range limit for BSL monitoring and a schedule for indwelling catheter changes. (iii). One rest home level resident care plan did not include the need to elevate a leg with a chronic ulcer (and this was not evidenced to be occurring).	(i). Ensure that neurological observations are completed for any unwitnessed falls with a potential head injury. (ii) – (iii). Ensure that the care plans include interventions to support the care and support needs for residents 90 days
Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	PA Low	Activity plans were documented for all eight resident files reviewed. All activity plans were resident centred and comprehensive for the daytime. The activity plans for the residents in the dementia unit did not all cover a 24-hour period.	Of the three-dementia level resident files reviewed, two of the activity plans did not cover a 24-hour period.	Ensure that each resident in the dementia unit has an activity plan that covers a 24-hour time span. 90 days

Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.	PA Low	There is a comprehensive preventative and maintenance schedule that has been implemented, water temperatures have been monitored monthly, but not in the resident areas.	Water temperatures have not been monitored in the resident areas.	Ensure that water temperatures are monitored in the resident areas. 60 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.