

Summerset Care Limited - Summerset at Heritage Park

Introduction

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

The audit has been conducted by BSI Group New Zealand Ltd, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

Legal entity:	Summerset Care Limited
Premises audited:	Summerset at Heritage Park
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 18 March 2021 End date: 19 March 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:	57

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 at Heritage Park provides rest home and hospital (geriatric and medical) level care for up to 78 residents, which includes 58 beds in their care centre and 20 serviced apartments that are certified for rest home level of care. On the day of the audit there were 57 residents.

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 and staff.

The village manager is appropriately qualified and experienced and is supported by a care centre manager (registered nurse) who oversees the clinical services. There are quality systems and processes being implemented. Induction and in-service training programmes are in place to provide staff with appropriate knowledge and skills to deliver care. The residents and relatives interviewed spoke positively about the care and support provided.

This are two areas of continuous improvement awarded around good practice and the activities programme.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		All standards applicable to this service fully attained with some standards exceeded.
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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. Policies are available that support residents' rights. Cultural assessment is undertaken on admission and during the review process. Residents and family interviewed verified ongoing involvement with the community. 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 at Heritage Park has an established quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to the 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 registered nurses are responsible for each stage of service provision. Residents' records reviewed provided evidence that the registered nurses utilise the interRAI assessment to assess, plan and evaluate care needs of the residents. These are then reviewed and discussed with the resident and/or family/whānau input. Care plans viewed demonstrated service integration and are reviewed at least six-monthly. Resident files include medical notes by the contracted general practitioner (GP), and visiting allied health professionals.

All staff responsible for the administration of medicines complete education and medication competencies. The electronic medication charts are reviewed both three-monthly by the general practitioner.

The diversional therapist and recreational therapist implement the activity programme to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and themed celebrations. Residents and families reported satisfaction with the activities programme.

All meals are cooked on site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. There are nutritious snacks available at all times. The organisational dietitian reviews the Summerset menu plans.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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Appropriate training, information and equipment for responding to emergencies are provided. There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency. There is an approved evacuation scheme and emergency supplies for at least three days. At least one first aid trained staff member is on duty at all times.

The building holds a current building warrant of fitness. All internal and external areas are safe and well maintained. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Chemicals are stored securely throughout the facility. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances. Electrical equipment has been tested and tagged. All medical equipment and all hoists have been serviced and calibrated (where applicable). Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. Cleaning and laundry services are well monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies are provided. There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency. There is an approved evacuation scheme and emergency supplies for at least three days. At least one first aid trained staff member is on duty at all times.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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There are documented policies and procedures around restraint use and use of enablers. During the audit, there was one resident using restraint and one resident using an enabler. Staff training around the use of restraint and enablers is provided. Restraint is only used as a last resort.

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.
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator is responsible for coordinating education and training for staff. The infection control coordinator has completed annual training provided by Summerset head office and DHB training. There is a suite of infection control policies and guidelines available electronically to support practice. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. The service engages in benchmarking with other Summerset facilities. There have been no outbreaks since the previous audit.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	2	48	0	0	0	0	0
Criteria	2	99	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Discussions with three managers (care centre manager, village manager, regional quality manager) and eleven staff (three caregivers who provide care to rest home and hospital level residents in the care centre and serviced apartments and work across all three shifts; three registered nurses (RNs) including one clinical nurse leader (CNL); one diversional therapist; two cooks; one property manager; one cleaner) confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and its application to their job role and responsibilities. Seven residents (four rest home including one resident in a serviced apartment, and three hospital) and four relatives (two rest home, two hospital) interviewed, confirmed the services being provided are in line with the Code. Observations during the audit also confirmed this in practice.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. Written general and specific consents were sighted in the eight resident files reviewed (three rest home and five hospital). Caregivers and registered nurses (RNs) interviewed, confirmed verbal consent is obtained when delivering care.</p> <p>Resuscitation orders are appropriately signed by the resident and general practitioner. The service acknowledges the resident is for resuscitation in the absence of a signed directive by the resident. The general practitioner (GP) discusses resuscitation with families/enduring power of attorney (EPOA) where the resident is</p>

<p>make informed choices and give informed consent.</p>		<p>deemed incompetent to make a decision. Discussion with family members identified that the service actively involves them in decisions that affect their relative's lives.</p> <p>Seven resident files of long-term residents and one respite resident reviewed have signed admission agreements.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Residents are provided with a copy of the Code on entry to the service. Residents interviewed confirmed they are aware of their right to access independent advocacy services and advocacy pamphlets are available at reception. Discussions with relatives confirmed the service provided opportunities for the family/enduring power of attorney (EPOA) to be involved in decisions. The resident files include information on residents' family/whānau and chosen social networks.</p> <p>A community-based resident advocate is appointed who attends three-monthly residents' meetings and meets individually with residents who request an advocate to listen to their concerns.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Visitors were observed coming and going during the audit. Interviews with staff, residents and relatives confirmed residents are supported and encouraged to remain involved in the community and external groups. Relatives and friends are encouraged to be involved with the service and care. The service promotes community visitors to the village and encourages resident involvement. Community links have been enhanced within the village, focussing on bridging the gap between the retirement village and the care centre. This has created a more inclusive community (link CI 1.1.8.1). Village residents are reported by the care centre manager as having a more positive image of the care centre and a greater understanding of residents with dementia.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are readily available. Information about complaints is provided on admission. Interviews with residents and family members confirmed their understanding of the complaints process.</p> <p>There is an electronic complaint register that includes verbal and written complaints and evidence to confirm that complaints are being managed in a timely manner including acknowledgement, investigation, timelines, corrective actions (when required) and resolutions. In 2020 there were two complaints received with evidence of follow-up actions taken and feedback provided in staff meetings including corrective actions (if any). No complaints have been received year to date (2021).</p> <p>Complainants are provided with information on how to escalate their complaint through the Health and Disability Commissioner if resolution is not to their satisfaction.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>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. Residents and relatives interviewed confirmed that they were well informed about the Code. Three-monthly residents' meetings are held with the village manager, care centre manager and diversional therapist followed by a private meeting with a community-based advocate. These meetings provide the opportunity for residents to raise concerns. An annual residents/relatives survey is completed.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Care staff interviewed were able to describe the procedures for maintaining confidentiality of resident records, resident's privacy and dignity. Signage is placed on residents' doors whilst cares are being provided.</p> <p>Contact details of spiritual/religious advisors are available. Church services are provided on the premises. Residents and relatives interviewed reported that residents are able to choose to engage in activities and access community resources.</p> <p>There is an elder abuse and neglect policy with evidence of annual staff training on this topic. There was one suspected claim relating to abuse, received in September 2020. Corrective actions were implemented that included additional staff training around reporting suspected resident abuse.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>Summerset has a Māori health plan that includes a description of how they achieve the requirements set out in the contract. There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. The Code is posted in English and in te reo Māori in visible locations. At the time of the audit there were no residents that identified as Māori. Links are established with a Māori representative from the local Orakei marae. Staff interviewed were able to describe how they can ensure they meet the cultural needs of residents.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And</p>	FA	<p>An initial care planning meeting is carried out where the resident and/or whānau as appropriate/able are invited to be involved. Individual beliefs and values are further discussed and incorporated into the care plan. Six monthly multi-disciplinary team meetings occur to assess if needs are being met. Family is invited to attend. Discussions with family/whānau confirmed values and beliefs are considered. Residents interviewed confirmed that staff take into account their culture and values. There were three residents who identified as Chinese and</p>

<p>Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>five residents who identified as Iranian. Translation takes place either through staff, family or hand/facial gestures. Translation services are also available through the DHB if needed.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Staff job descriptions include responsibilities and staff sign a copy on employment. The monthly quality improvement meetings include discussions on professional boundaries and concerns as they arise. Management provide guidelines and mentoring for specific situations. Interviews with managers and staff confirmed their awareness of professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>CI</p>	<p>Residents and relatives interviewed spoke positively about the care and support provided. Staff have a sound understanding of principles of aged care and stated that they feel supported by the village manager and care centre manager. 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.</p> <p>There is a quality improvement programme that includes performance monitoring against clinical indicators and benchmarking against like services within the Summerset group of aged care facilities. There is evidence of education being supported in addition to the robust Summerset training plan. There are implemented competencies for caregivers and registered nurses including (but not limited to): insulin administration, medication, wound care and manual handling.</p> <p>The achievement of the rating that service provides an environment that encourages good practice is beyond the expected full attainment with examples provided.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and</p>	<p>FA</p>	<p>An open disclosure policy describes ways that information is provided to residents and families. The admission pack gives a comprehensive range of information regarding the scope of service provided to the resident and their family on entry to the service and any items they are to pay for that are not covered by the agreement. Regular contact is maintained with family including if an incident or care/health issue arises. Family members interviewed stated they were well-informed. Ten incident/accident forms were reviewed, and all identified that</p>

<p>provide an environment conducive to effective communication.</p>		<p>the next of kin were contacted.</p> <p>There are three-monthly resident's meetings with a portion of the meeting chaired by a resident advocate where any issues or concerns to residents are able to be discussed. Minutes are maintained and show follow-up actions for resolution of matters raised.</p> <p>The service has policies and procedures available for access to DHB interpreter services. The information pack is available in large print and can be read to residents.</p> <p>Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Summerset at Heritage Park provides rest home and hospital level care for up to 58 residents in their care centre. In addition, 20 serviced apartments are certified for rest home level of care. The rooms in the care centre are approved for both rest home or hospital level residents.</p> <p>On the day of the audit there were 54 residents in the care centre (18 rest home level and 36 hospital level) and three rest home level residents in the serviced apartments. Two residents in the care centre (one rest home, one hospital) were funded by ACC, one resident in the care centre (hospital) was on a younger person with a disability (YPD) contract and two residents (one rest home in a serviced apartment and one hospital) were on respite. All remaining residents were under the aged residential care contract (ARCC).</p> <p>A village manager who has been in the role for one year provides oversight to the entire village. She is supported by a care centre manager/RN who has been nursing for 20 years and has been a care centre manager at Summerset at Heritage Park for the past two years. A regional quality manager who has been in her role for two years was also available during the audit and provides assistance to the care centre manager. A (full-time) clinical nurse leader (CNL) also supports the care centre manager.</p> <p>The quality and risk management plan are updated each year with evidence of regular reviews of the facility's goals and objectives throughout the year.</p> <p>The village manager and care centre manager have maintained greater than eight hours of professional development activities related to their respective roles.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation</p>	<p>FA</p>	<p>During the temporary absence of the care centre manager, the clinical nurse manager (CNL) provides clinical leadership/oversight, and the village manager is delegated operational responsibilities. The regional operations manager and the regional quality manager also provide oversight and support.</p>

<p>of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>		
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>An annual quality and risk management plan is in place. Policies and procedures reflect evidence of regular reviews as per the document control schedule. New and/or revised policies are made available for staff to read and sign that they have read and understand the changes. Village managers and care centre managers are held accountable for their implementation.</p> <p>The monthly collating of quality and risk data includes (but is not limited to) residents' falls, bruising, skin tears and infection rates. Data is collated and benchmarked against other Summerset facilities to identify trends. A resident satisfaction survey is conducted each year. Results for 2020 reflected high levels of resident satisfaction with the services received. One quality improvement was initiated relating to food satisfaction.</p> <p>An annual internal audit schedule was sighted for the service. Corrective actions are developed where opportunities for improvements are identified and are signed off when completed. Staff are kept informed of audit findings and quality initiatives, documented on the audits completed and in the range of meeting minutes (eg, staff meetings, quality meetings, clinical meetings).</p> <p>A falls reduction plan was sighted for the service. Falls prevention strategies are in place that include the identification of interventions on a case-by-case basis to minimise future falls. Each resident undergoes a falls risk assessment to identify their risk of falling. A physiotherapist is available two days a week (8 hours total) to assist in the development of falls reduction strategies for at-risk residents. Quality initiatives implemented have included a strength and balance programme for residents and chair yoga exercises (link CI 1.1.8.1) with evidence to support the consistently low number of falls, averaging 13 per month over the past 18 months.</p> <p>The health and safety committee includes four trained health and safety representatives who meet monthly. Data relating to health and safety is entered into the electronic Risk Management Support System (RMSS). Hazard identification forms and a hazard register are in place. Health and safety and fire training commence during staff orientation. This includes manual handling training, infection control training, Covid-19 prevention and outbreak planning and displaying health and safety 'golden rules and actions taken to remove a hazard or prevent an accident. The village risk register is reviewed and updated monthly.</p>
<p>Standard 1.2.4: Adverse</p>	<p>FA</p>	<p>The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident (events) information. The reporting system is integrated into the</p>

<p>Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>quality and risk management programme. Ten incident reports, held electronically, were sampled (six unwitnessed falls, one pressure injury, one challenging behaviour, two soft tissue injuries (skin tears). All ten events sampled evidenced clinical follow up. Neurological observations are completed as per protocol for any unwitnessed fall or suspected injury to the head. Adverse events are reviewed and investigated by the care centre manager. If risks are identified these are processed as hazards.</p> <p>Discussions with the village manager and care centre manager have confirmed their awareness of statutory requirements in relation to essential notification. Section 31 notifications since the previous audit have included residents with challenging behaviours and pressure injuries.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Job descriptions were sighted for all relevant positions that describe staff roles, responsibilities and accountabilities. The practising certificates of nurses and external health professionals are current (eg, GP, pharmacist, podiatrist, dietitian and physiotherapists).</p> <p>Seven staff files were reviewed (five caregivers, two RNs). Evidence of signed employment contracts, job descriptions, completed orientation that is specific to their job duties, and staff attendance at more than eight hours of education and training annually were sighted. Performance appraisals for staff are conducted during their orientation (three and six monthly and annually thereafter). Interviews with the staff confirmed that the orientation programme includes a period of supervision.</p> <p>Seven of twelve RNs are trained in interRAI. Forty caregivers are employed. Eight have completed a level two Careerforce qualification, ten have completed a level three Careerforce qualification and twelve have completed a level four Careerforce qualification. Three caregivers are currently studying nursing.</p> <p>The service has a training policy and schedule for in-service education. The in-service schedule is implemented, and attendance is recorded. In-services are offered multiple times across the three shifts. In-service education is supported by competency assessments (hand hygiene, moving and handling, wound care, restraint, syringe driver, medication administration).</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</p>	<p>FA</p>	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery.</p> <p>At the time of the audit there were 54 residents living in the care centre, which is located on the first level (36 hospital level and 18 rest home level), and three rest home level residents in the serviced apartments, with all three living in close proximity on the ground level.</p> <p>The care centre manager is a registered nurse who is rostered Monday – Friday. She is supported by a CNL who is employed Sunday – Thursday. Two RNs are rostered on the AM shift with a third RN on the two days/week of GP rounds and on the two days when the CNL is not available (Friday and Saturday). Two RNs</p>

<p>providers.</p>		<p>are rostered on the PM and the night shifts.</p> <p>Ten caregivers are rostered on the AM shift (six long shift and four short shift); eight caregivers are rostered on the PM shift (six long shift and two short shift) and two caregivers are rostered during the night shift.</p> <p>One caregiver is allocated on each of the three shifts for the serviced apartments. There is separate laundry staff on the AM and PM shifts with the night staff assisting with laundry duties.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The resident files were appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access. Care plans and progress notes are documented electronically. Resident files demonstrated service integration.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>There is an implemented Summerset admission policy and procedures to safely guide service provision and entry to the service. All residents have a needs assessment completed prior to entry that identifies the level of care required. The care centre manager and clinical nurse leader screen all potential enquiries to ensure the service can meet the required level of care and specific needs of the resident. The service has an information pack available for residents/families/whānau at entry. The admission information pack outlines access, assessment and the entry screening process. The service operates twenty-four hours a day, seven days a week. Comprehensive information about the service is made available to referrers, potential residents and their families. Resident agreements contain all detail required under the ARCC. The eight admission agreements reviewed meet the requirements of the ARCC and were signed and dated. Exclusions from the service are included in the admission agreement.</p> <p>Family members and residents interviewed stated that they have received the information pack and have received sufficient information prior to and on entry to the service. Family members reported that the care centre manager or clinical nurse leader are available to answer any questions regarding the admission process.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p>	<p>FA</p>	<p>The service has a policy that describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident's electronic file. All relevant information is documented and communicated to the receiving health provider or service. Transfer notes and discharge</p>

<p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>		<p>information was available in resident records of those with previous hospital admissions. One file reviewed was of a serviced apartment resident who had been transferred to hospital acutely post fall and then subsequently been admitted in to full time care in the facility. All appropriate documentation and communication were completed. Transfer to the hospital and back to the facility post-discharge was well documented in progress notes. Communication with family was made in a timely manner.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were eleven residents self-administering on the day of audit. The residents had current assessments, safe storage of their medication within their rooms and those sampled could describe the need and process for these when interviewed. All legal requirements had been met. There are no standing orders in use. There are no vaccines stored on site. All clinical staff (RNs, med-comp caregivers) who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Registered nurses have completed syringe driver training. Staff were observed to be safely administering medications. Registered nurses and a caregiver interviewed could describe their role regarding medication administration. The service currently uses robotics for regular medication and 'as required' medications. All medications are checked on delivery against the medication chart (medimap) and any discrepancies are fed back to the supplying pharmacy. Medications were appropriately stored in the facility medication room. The medication fridge and medication room temperatures are monitored daily, and the temperatures were within acceptable ranges. All medications including the bulk supply order are checked weekly. All eyedrops have been dated on opening.</p> <p>Staff sign for the administration of medications electronically. Sixteen electronic medication charts were reviewed. The medication charts reviewed identified that the GP had reviewed all resident medication charts three monthly. Each drug chart has a photo identification and allergy status identified. 'As required' medications had indications for use charted.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The meals at Summerset at Heritage Park are all prepared and cooked on site. The kitchen was observed to be clean, well-organised and a current approved food control plan was in evidence. There is a twelve-weekly seasonal menu that is designed and reviewed by a registered dietitian at an organisational level. The chef receives resident dietary information from the RNs and is notified of any changes to dietary requirements (vegetarian, pureed foods) or of any residents with weight loss. The head chef (interviewed) was aware of resident likes, dislikes and special dietary requirements. Alternative meals are offered for those residents with dislikes or religious preferences. Residents have access to nutritious snacks 24 hours a day. On the day of audit, meals were observed to be well presented.</p> <p>Kitchen fridge and freezer temperatures are monitored and recorded daily. Food temperatures are checked at</p>

		<p>all meals. These are all within safe limits. Staff were observed wearing correct personal protective clothing in the kitchen and in the serveries. Cleaning schedules are maintained. Staff were observed assisting residents with meals in the dining rooms and modified utensils are available for residents to maintain independence with meals. Food services staff have all completed food safety and hygiene courses. There is a food control plan expiring 3 March 2022.</p> <p>The residents interviewed were satisfied with the food service and the variety and choice of meals provided. They can offer feedback on a one-to-one basis, at the resident meetings and through resident surveys.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The service records the reason for declining service entry to potential residents should this occur and communicates this to the consumer and where appropriate their family/whānau member of choice. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. The initial support plan is developed by the registered nurses with information from the initial assessment and information provided from discharge summaries, allied health professionals and in consultation with the resident/relatives.</p> <p>The service uses the Vcare assessments for short-term respite residents and a combination of Vcare and interRAI assessments for all long-term residents (including YPD and ACC). These are completed on admission and reviewed six-monthly as part of the evaluation unless changes occur prior, in which case a review is carried out at that time. InterRAI assessments had been completed for all long-term residents' files reviewed. These were within timeframes and areas triggered were addressed in the care plans sampled.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are</p>	FA	<p>Eight resident files were reviewed across a range of conditions including (but not limited to) pressure injury, diabetes, mental health, behaviour that challenges, falls, and weight loss. In all files reviewed the care plans were comprehensive, addressed the resident need and were integrated with other allied health services involved in resident care. Service integration was evidenced by documented input from a range of specialist</p>

<p>consumer focused, integrated, and promote continuity of service delivery.</p>		<p>care professionals, including the podiatrist, dietitian, and mental health care team for older people. Relatives and residents interviewed all stated they were involved in the planning of resident care. In all files reviewed there is evidence of resident and relative involvement in care planning. Activity assessments were completed by the activities staff within three weeks of admission. Care plans reviewed provided evidence of individualised support. Short-term care plans are in use for short-term needs and changes in health status. The care staff interviewed advised that the care plans were easy to follow. Integration of records and monitoring documents are well managed.</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 registered nurses complete care plans for residents. Progress notes in all files reviewed had details which reflected the interventions documented in the long-term care plans. When a resident's condition alters, the registered nurse initiates a review and if required, GP or specialist consultation. Short-term care plans are documented for changes in health status. Staff stated that they notify family members about any changes in their relative's health status, and this was confirmed by family members interviewed, who stated they are notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. Evidence of relative contact for any changes to resident health status was viewed in the resident files sampled. Care plans reviewed documented sufficient detail to guide care staff in the provision of care. A physiotherapist is contracted to assess and assist residents' mobility and transfer needs as required.</p> <p>Wound assessment, appropriate wound management and ongoing evaluations are in place for all wounds. Wound monitoring occurred as planned and is documented on both a paper-based wound log and the VCare system. There were nine ongoing wounds including two abrasions, four skin tears, one cellulitis, one excoriation and one grade 1 pressure injury (facility acquired). There service has access to a wound nurse specialist as required for input and advice.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the RNs interviewed. Care staff stated there are adequate clinical supplies and equipment provided, including continence and wound care supplies, and these were sighted on day of audit.</p> <p>Monitoring charts sighted included (but are not limited to), vital signs, blood glucose, pain, food and fluid, turning charts, neurological observations, bowel monitoring and behaviour monitoring. All monitoring requirements including neurological observations had been documented as required.</p> <p>Care plans have been updated as residents' needs changed. The GP interviewed was complimentary of the service and care provided.</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 and one recreational therapist covering Monday to Sunday between them, who plan and lead the activities in the home. There are set Summerset activities including themes and events which the activities team add to, in order to individualise activities to resident need and preferences. A weekly activities calendar is distributed to residents, posted on noticeboards and is available in large print. On the days of audit, residents were observed participating in activities. The diversional therapist seeks verbal feedback on activities from residents and families to evaluate the effectiveness of the activity programme, enabling further adaptation if required. Residents interviewed were positive about the activity programme.</p> <p>Residents are able to participate in a range of activities that are appropriate to their cognitive and physical capabilities. There are weekly outings to places chosen by the residents and there are regular entertainers visiting the facility. Special events like birthdays, Easter, Mothers' Day, Anzac Day and other cultural festive days are celebrated. There are visiting community groups such as local church groups, pet therapy and visiting schools. The activity team provide a range of activities which include (but are not limited to) exercises, walks outside, crafts, games, quizzes, entertainers, gardening and bingo. The diversional therapist and management team have actively sought to integrate care and village residents through joint activities, an ambassador scheme to reduce social isolation and the use of diversional therapy students on placement with the facility.</p> <p>The activity team are involved in the admission process, completing the initial activities assessment, and have input in to the cultural assessment. An activities plan is completed within timeframes, a monthly record of attendance is maintained, and evaluations are completed six-monthly.</p> <p>Those residents who prefer to not to participate in communal activities receive one-on-one visits and individualised activities such as pampering sessions according to their preferences. The service has also invested in two INMU musical therapy devices for certain residents with anxiety and/or other cognitive issues.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The seven long-term (including ACC and YPD but excluding short-term respite) resident care plans reviewed had been evaluated by the registered nurses six-monthly or earlier if there was a change in health status. Activities plans are in place for each of the residents and these are also evaluated six-monthly. There are three-monthly reviews by the GP for all residents which family are able to attend if they wish to do so. Six monthly multi-disciplinary reviews and meeting minutes are completed by the registered nurse with input from caregivers, the GP, activities team, resident and family/whānau members and any other relevant person involved in the care of the resident. The contracted GP reviews the resident at least three-monthly. Short-term care plans are in use for acute and short-term issues. These are evaluated at regular intervals.</p>
<p>Standard 1.3.9: Referral To Other Health And</p>	<p>FA</p>	<p>Summerset at Heritage Park facilitates access to other medical and non-medical services. Referral to other health and disability services is evident in the sample group of resident files. The RNs initiate referrals to nurse</p>

<p>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>		<p>specialists, and allied health services. Other specialist referrals are made by the GP. Referrals and options for care were discussed with the family, as evidenced in medical notes. Referral documentation is maintained on resident files. The registered nurse interviewed could describe examples of where a resident's condition had changed, and the resident care plan had been changed to reflect updated interventions accordingly. Discussion with the registered nurses identified that the service has access to a wide range of support either through the GP, specialists and allied health services as required.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>There are policies and documented processes regarding chemical safety and waste disposal in place. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas. Safety datasheets and product sheets are available and readily accessible for staff. Sharp's 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 and were seen to be worn by staff when carrying out their duties on the day of audit. A spills kit is available.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building holds a current building warrant of fitness, which expires on 15 August 2021. A request book for repairs is maintained and signed off as repairs are completed. There is a full-time property manager and four maintenance staff who carry out the 52-week planned maintenance programme. The property manager is also on call after hours for urgent matters. The checking and calibration of medical equipment including hoists, has been completed annually and is next due January 2022. All electrical equipment has been tested and tagged and is next due in June 2023. Hot water temperatures have been tested and recorded monthly with corrective actions for temperatures outside of the acceptable range. Preferred contractors are available 24/7.</p> <p>The corridors are wide and promote safe mobility with the use of mobility aids and transferring equipment. Residents were observed moving freely around the areas with mobility aids, where required. There is outdoor furniture and seating with shade in place, and there is safe access to all communal areas. The external areas are landscaped and are wheelchair accessible.</p> <p>The caregivers and RNs interviewed stated that they have all the equipment required to provide the care documented in the care plans.</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>	<p>FA</p>	<p>All bedrooms apart from four standard rooms have ensuites. There are sufficient communal shower and toilet facilities to service these standard rooms. Visual inspection evidenced toilet and shower facilities are of an appropriate design to meet the needs of the residents and there is ample space in toilet and shower areas to accommodate shower chairs and a hoist if required. There are adequate numbers of communal toilets located near the communal areas. Communal toilet/shower facilities have a system that indicates if it is engaged or vacant.</p> <p>Fixtures, fittings, floorings and wall coverings are in good condition and are made from materials which allow for ease of cleaning.</p> <p>Privacy curtains are in shower rooms. Residents interviewed reported their privacy is maintained at all times.</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>	<p>FA</p>	<p>All resident rooms are single and spacious enough to safely manoeuvre mobility aids and transferring equipment such as hoists in the resident bedrooms. The doors are wide enough for ambulance trolley access. Staff interviewed reported that they have more than adequate space to provide care to residents.</p> <p>Residents are encouraged to personalise their bedrooms with personal belongings 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>	<p>FA</p>	<p>There are large and small communal areas within the facility that include a large main lounge and adjacent dining room. There is also a large family room with tea/coffee making facilities. Activities occur in all lounges which are large enough to cater for the activities on offer, are accessible and can accommodate the equipment required for the residents. There are sufficient lounges and private/quiet seating areas where residents who prefer quieter activities or visitors may sit. The lounge and dining areas are spacious, inviting and appropriate for the needs of the residents. Residents are able to move freely through and around these areas and furniture is placed to facilitate this. Residents were seen to be moving freely both with and without assistance during the audit.</p>

<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. There are designated cleaning/laundry staff on duty seven days a week. There is an entry and exit door with a defined clean/dirty area. The laundry is well equipped, and all machinery has been serviced regularly.</p> <p>There is a cleaning manual available. Cleaning and laundry services are monitored through the internal auditing system. Cleaning trolleys sighted were well equipped and are kept in designated locked areas when not in use.</p> <p>Sluice rooms were kept locked when not in use. Residents and family interviewed reported satisfaction with the cleaning and laundry service.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>There is an emergency and civil defence plan to guide staff in managing emergencies and disasters. Emergencies and first aid are included in the mandatory in-service programme. There is a first aid trained staff member on every shift and on outings.</p> <p>Summerset at Heritage Park has an approved fire evacuation plan and fire drills occur six-monthly. Smoke alarms and exit signs are in place. The service has alternative cooking facilities (barbeque) available in the event of a power failure. Water stores in the event of an emergency are stored in the ceiling with additional stored bottled water also available. The service holds at least three days of food storage. A generator is available on the premises for emergency power.</p> <p>Call bells were evident in resident's rooms, lounge areas, and toilets/bathrooms. The facility is secured at night.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>All bedrooms and communal areas are appropriately heated, have ample natural light and ventilation. The facility has under floor heating that is thermostatically controlled. Staff and residents interviewed stated that this is effective. All bedrooms and communal areas have at least one external window. There is a monitored outdoor area where residents may smoke. All other areas are smoke free.</p>
<p>Standard 3.1: Infection control management</p>	<p>FA</p>	<p>The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Staff are well-informed about infection control practises and reporting. The</p>

<p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>		<p>infection control coordinator (ICC) is an RN who is responsible for infection control across the facility as detailed in the ICC job description (signed copy sighted on day of audit). The ICC oversees infection control for the facility, reviews incidents on VCare and is responsible for the collation of monthly infection events and reports. The infection control committee and Summerset head office are responsible for the development and review of the infection control programme.</p> <p>Hand sanitisers are appropriately placed throughout the facility. Visitors are asked not to visit if they are unwell. Residents are offered the influenza vaccine. There have been no outbreaks since the last audit.</p> <p>Covid-19 education has been provided for all staff, including hand hygiene, donning/doffing and use of PPE.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>There are adequate resources to implement the infection control programme at Summerset at Heritage Park. The ICC liaises with the infection control committee who meet monthly and as required (more frequently during Covid lockdown). Information is shared as part of staff meetings and also as part of the registered nurse meetings. The ICC has completed annual training in infection control. External resources and support are available through the Summerset regional quality manager, external specialists, microbiologist, GP, wound nurse and DHB when required. The GP monitors the use of antibiotics. Overall effectiveness of the programme is monitored by Summerset head office.</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</p>	<p>FA</p>	<p>The infection control policies include a comprehensive range of standards and guidelines including defined roles and responsibilities for the prevention of infection, the infection control team, and training and education of staff. Infection control procedures developed in respect of care, the kitchen, laundry and housekeeping incorporate the principles of infection control. Policies are updated regularly and directed from Summerset head office.</p>

appropriate/suitable for the type of service provided.		
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The ICC is responsible for coordinating/providing education and training to staff. The orientation package includes specific training around hand hygiene and standard precautions. Annual infection control training is included in the mandatory in-services that are held for all staff, and staff have completed infection control education in the last 12 months. The infection control coordinator has access to the Summerset ILearn intranet with resources, guidelines for best practice, education packages and group benchmarking. The ICC has also completed infection control audits.</p> <p>Resident education occurs as part of providing daily cares and as applicable at resident meetings.</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>	FA	<p>Surveillance is an integral part of the infection control programme and the purpose and methodology are described in the Summerset surveillance policy. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility.</p> <p>Monthly infection data is collected for all infections based on standard definitions as described in the surveillance policy. Infection control data is monitored and evaluated monthly and annually. Trends are identified, and analysed, and preventative measures put in place. These, along with outcomes and actions are discussed at the infection control meetings. Meeting minutes are available to staff.</p> <p>Infections are entered into the electronic database (VCare) for benchmarking. Corrective actions are established where trends are identified.</p> <p>Systems in place are appropriate to the size and complexity of the facility.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There are policies around restraints and enablers. The service had one (hospital) resident assessed as requiring the use of a restraint (lap belt) and one resident (hospital) requiring an enabler (lap belt). The care plans provide the basis of factual information in assessing the risks of safety and the need for restraint. Ongoing consultation with the resident and family/whānau are identified. Staff receive training around restraint minimisation that includes annual competency assessments.</p> <p>The hospital level resident using an enabler (lap belt) has been assessed as safe to use the enabler. Voluntary consent for the enabler was provided by the resident.</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>	<p>FA</p>	<p>A restraint approval process and a job description for the restraint coordinator are in place. The restraint coordinator role is delegated to the clinical nurse lead. He has been in this role for one year and is supported by a restraint committee (one RN and two caregivers). All staff are required to attend restraint minimisation training annually and to complete a restraint competency assessment annually.</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>	<p>FA</p>	<p>Only registered nursing staff can assess the need for restraint. Restraint assessments are based on information in the resident's care plan, discussion with the resident and family and observations by staff. The restraint assessment tool meets the requirements of the standard. The one hospital level resident file where restraint was being used was selected for review. This file included a restraint assessment and consent form that was signed by the resident's family. Restraint use is linked to the resident's care plan, relevant risks are identified, and the restraint is regularly reviewed.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>A restraint register is in place. This register identifies the residents that are using either a restraint or an enabler, and the type(s) of restraint used. The restraint assessment identifies that restraint is being used only as a last resort. The restraint assessment and ongoing evaluation of restraint use includes reviewing the frequency of monitoring residents while on restraint. Monitoring forms are completed when the restraint is put on and when it is taken off and indicates monitoring at the frequency described in the resident's care plan.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>Restraint use is reviewed monthly during restraint meetings and three-monthly by the restraint coordinator. The review process includes discussing whether continued use of restraint is indicated.</p>

<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The restraint programme, including reviewing policies and procedures and staff education, is evaluated annually by the Somerset head office.</p>
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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 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>A list of quality initiatives that have been implemented since the previous audit have reflected attainment beyond what is expected from a rating of fully attained.</p>	<p>The achievement of the rating that service provides an environment that encourages good practice is beyond the expected full attainment. The service has conducted a number of quality improvement projects where a review process has occurred, including analysis and reporting of findings has occurred. There is evidence of actions taken based on findings that has made improvements to service provision. The projects include reviewing if the improvements have had positive impacts on resident safety or resident satisfaction. Examples provided include bridging the gap between the care centre and village residents, creating a more inclusive community; appointing Summerset ambassadors to promote friendships within the care centre and helping to reduce the risk of social isolation with very positive feedback received from the residents; implementation of a yoga strength and balance falls prevention programme with high attendance rates; implementation of interactive music therapy which has been successfully used to de-escalate residents with challenging behaviours as well as comfort residents who are anxious, grieving or at end of life; implementation of a dance therapy programme, cognitive stimulation programme and sensory stimulation programme, especially directed to those residents with dementia; keeping residents and family connected during the Covid-19 lockdown through zoom meetings, facetime and email; improved staff retention with reduced use of agency staff and</p>

			reducing the number of urinary tract infections to nil during the month of December 2020.
<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>The 2019 and 2020 satisfaction surveys show high satisfaction relating to activities in the service. The approach implemented relating to activities is one of integration and a focus on 'making a difference in the surrounding community as a whole' is evident within the facility.</p> <p>The community programmes and events that have been implemented are supported and enjoyed by the residents, family and the wider community.</p> <p>By bridging the gap between care centre and village units, a more inclusive community has been achieved by Summerset at Heritage Park. Village residents also have a greater understanding, and appreciation of care while those in care have benefitted from a</p>	<p>The activities programme shows evidence beyond the expected full attainment, enabling residents to integrate, engage with, and make a meaningful contribution to their surrounding community. The residents who wish to have an opportunity to contribute in a meaningful way to the wellbeing of the community are supported by the service and provided with opportunity. Evaluations evidenced through consumer satisfaction surveys show an increase from 96% to 98% satisfaction with community engagement in 2019 and 2020.</p> <p>The activity programme evidenced the actions taken to make the programme meaningful to the residents.</p>

		<p>reduction in stigma especially related to dementia.</p> <p>The use of ambassadors has helped to promote friendships through shared experiences. It has also facilitated feelings of self-worth through supported participation and helped to reduce the risk of social isolation, especially during Covid lockdown periods. Residents from both care and village had given filmed testimonies to the effectiveness of the programme and the benefits they had experienced. This was viewed at the time of audit.</p>	
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End of the report.