

Summerset Care Limited - Summerset at Wigram

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 Wigram

Services audited: Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

Dates of audit: Start date: 27 May 2021 End date: 28 May 2021

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 58

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Summerset at Wigram provides rest home and hospital (medical and geriatric) level care for up to 52 residents in the care centre and up to 20 residents at rest home level care across the 53 care apartments. On the day of the audit, there were 58 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, staff and a general practitioner.

The service is managed by a village manager and a care centre manager. There are quality systems and processes being implemented. An induction and in-service training programme are in place to provide staff with appropriate knowledge and skills to deliver care. The service continues to have a resident centred approach to care, and encourage all residents in the village, serviced apartments and the care centre to be part of a community. The residents and relatives interviewed spoke positively about the care and support provided.

This audit identified the service is meeting the health and disability sector standards.

The service has achieved a continuous improvement rating around falls prevention, activities, and infection control.

Consumer rights

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

Standards applicable to this service fully attained.

Policies are documented to support resident rights. Systems protect their physical privacy and promote their independence. There is a documented Māori health plan in place which acknowledges the principles of the Treaty of Waitangi. Individual care plans include reference to residents' values and beliefs.

Residents and relatives are kept up to date when changes occur or when an incident occurs. Systems are in place to ensure residents are provided with appropriate information to assist them to make informed choices and give informed consent.

A complaints policy is documented that aligns with the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). A complaints register is maintained. Staff interviews confirmed an understanding of the complaints process.

Consents are documented by residents or family and there are advance directives documented if the resident is competent to complete these.

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.

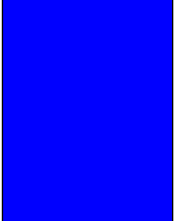
Organisational performance is monitored through several processes to ensure it aligns with the identified values, scope, and strategic direction. The business plan is tailored to reflect the goals related to Summerset Wigram. There are policies and

procedures to provide appropriate support and care to residents with hospital and rest home level needs. This includes a documented quality and risk management programme that includes analysis of data. Meetings are held at regular intervals to discuss quality and risk management and to ensure these are further embedded into practice. There is a health and safety management programme that is implemented with evidence that issues are addressed in a timely manner.

An orientation programme is in place and there is ongoing training provided as per the training plan developed for 2021. Rosters and interviews indicated sufficient staff that are appropriately skilled, with flexibility of staffing around clients' needs. A roster provides sufficient and appropriate coverage for the effective delivery of care and support including planned staffing for the rest home residents in serviced apartments. Registered nursing cover is provided twenty-four hours a day, seven days a week.

The residents' files are appropriate to the service type.

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.
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The service has assessment processes and resident's needs are assessed prior to entry. There is a comprehensive pack available for residents and families/whānau at entry. Assessments, resident care plans, and evaluations were completed by the registered nurses within the required timeframes. Electronic risk assessment tools and monitoring forms were available and implemented. Resident care plans were tailored to individual need and included allied health professional involvement in resident care.

The activities team and team of volunteers implement an integrated activity programme. The activities meet the individual recreational needs and preferences of the resident groups. There are outings into the community and visiting guests/entertainers.

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

The food service is contracted to an external company. Individual dietary needs of residents were identified and accommodated. A current food control plan is in place. Residents interviewed were complimentary of the food services.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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There were documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Chemicals were stored safely throughout the facility, and staff have completed chemical safety training. The building has a current warrant of fitness. Resident rooms and bathroom facilities are spacious. All communal areas within the facility are easily 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. There is a first aid trained staff member on duty 24 hours. Housekeeping/laundry staff maintain a clean and tidy environment. 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.
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Restraint minimisation and safe practice policies are in place to guide staff in the use of an approved enabler and/or restraint. On the day of audit there were no residents using restraint and three using an enabler. Staff training has been provided 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.

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

The infection control programme is appropriate for the size and complexity of the service. The infection control coordinator (registered nurse) is responsible for coordinating and providing education and training for staff. The infection control manual outlined the scope of the programme and included a comprehensive range of policies and guidelines. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This included audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Somerset facilities. There has been one outbreak since the previous audit. Covid-19 was well prepared for with adequate supplies of personal protective equipment sighted and isolation kits centrally located on all levels.

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	43	0	0	0	0	0
Criteria	3	90	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
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. The policy relating to the Code is implemented and staff interviewed (six caregivers, five registered nurses (RN), two enrolled nurses (EN) one diversional therapist, one property manager, one village manager, one regional quality manager, a care centre manager, one housekeeper, one laundry staff and the kitchen manager) 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	FA	<p>There are policies and procedures in place for informed consent. Admission agreements were sighted, signed and scanned onto the electronic resident management system. Permissions granted, information on making complaints including health and disability complaints and accessing the advocacy service were included in the admission agreement.</p> <p>Written general consents, consent for video and photos to be taken, and specific consents (flu and Covid vaccinations) were evident in the resident files reviewed. All staff interviewed fluently described where consent is gained during delivery of cares. Advance directives had been appropriately signed by the resident and general practitioner (GP). Where the resident is deemed unable to make a decision the GP makes a medical decision in consultation with the activated enduring power of attorney. The service acknowledges the</p>

give informed consent.		resident is for resuscitation in the absence of a signed directive by the resident. Advance care plans where available were kept on the resident file. Discussion with relatives identified that the service actively involves them in decisions that affect residents' lives.
<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>	FA	<p>Information on advocacy services is included in the resident information pack that is provided to new residents and their family on admission. Advocacy brochures are also available at reception. Advocacy representatives attend meetings bi-monthly and advises residents on how to lodge a complaint or compliment and explains their rights. Interviews with residents and relatives confirmed their understanding of the availability of advocacy services.</p> <p>The complaints process is linked to advocacy services with this offered to any complainant if required.</p> <p>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.</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>	FA	<p>The resident information pack informs that visiting can occur at any reasonable time. Interviews with residents and family confirmed that visiting can occur at any time. Family members were seen visiting on the days of the audit. Key people involved in the resident's life are documented in the care plans. The main doors lock automatically at 8:30 pm and independent residents hold a swipe card to enter the village after doors are locked. Family is able to access staff via an intercom if they wish to visit after hours.</p> <p>The service has a central café close to the entrance. This is open to the public and used extensively by care centre residents, village residents and family. Residents from the adjacent village are encouraged to join in care centre activities with entertainment and are offered opportunities to volunteer. The 2020 annual residents/relatives survey reports overall 90% positive feedback with the level of engagement with outside community groups.</p> <p>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.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is</p>	FA	<p>The organisational complaints policy states that the village manager has overall responsibility for ensuring all complaints (verbal or written) are fully documented and investigated. The care centre manager is responsible at this facility for addressing any complaints in consultation with the village manager.</p> <p>A complaints procedure is provided to residents within the information pack at entry. Feedback forms are</p>

understood, respected, and upheld.		<p>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 nine formal complaints lodged in 2020 and one in 2021 year to date. All were reviewed, and this confirmed that complaints are responded to in a timely manner as per policy with complainants confirming that they were happy with the outcome.</p> <p>Seven of the ten complaints raised over 2020 and 2021 related to communication issues with family. Minutes of meetings with RNs and care staff evidenced discussion and plans to raise awareness. Residents and relatives interviewed stated communication from all staff was excellent. Two relatives interviewed stated that their concerns had been dealt with in a timely manner to their satisfaction. They also stated that the clinical care manager had an open door which allowed for discussion and encouraged any concerns to be raised.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>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.</p> <p>Discussions relating to the Code are also held during the resident/family and bi-monthly advocacy meetings. Six residents interviewed (two rest home and four requiring hospital level care) confirmed that they received cares that met their needs, and all were aware of their rights. Six family members interviewed (five with family requiring hospital level care and one rest home care) confirmed that staff had informed them of the Code.</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>The residents' personal belongings are used to decorate their rooms. There are rooms with ensuites and there are communal toilets as well. All have locks to ensure privacy.</p> <p>Discussions with residents and relatives confirmed the staff are respectful and that their privacy is respected, and that cultural and/or spiritual values and individual preferences are identified. Care plans reviewed identified specific individual likes and dislikes. Caregivers reported that they promote the residents' independence by encouraging them to be as active as possible. All the residents and relatives interviewed confirmed that privacy is respected.</p> <p>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.</p> <p>There are spiritual services and residents are encouraged to attend their own spiritual care in the community. There is at least one church service a week, all residents have the opportunity to attend. Spiritual needs are individually identified as part of the assessment and care planning process.</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>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 clinical 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. There were no residents living at the facility who identified as Māori.</p> <p>Discussions with staff confirmed an understanding of the different cultural needs of residents and their whānau. Staff receive annual education on cultural awareness that begins during their induction to the service.</p> <p>There is Māori health plan with goals to improve outcomes for residents. The service can also access support through the Māori Health Unit at the district health board and Rehua Marae and the Te Puawaitangi Ki Otautahi Trust if required.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The service identifies the residents' personal needs and wishes from the time of admission. This is achieved in consultation with the resident, family and/or their representative. Staff interviewed confirmed that they are committed to ensuring each resident is known and treated as an individual. Beliefs and values are discussed and incorporated into the care plan as sighted in the review of the resident files reviewed. Residents and relatives interviewed confirmed they are involved in developing the resident's plan of care, which includes the identification of individual values and beliefs.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>There are implemented policies and procedures to protect clients from abuse, including discrimination, coercion, harassment, and exploitation, along with actions to be taken if there is inappropriate or unlawful conduct. Job descriptions include responsibilities and expectations of the position. The comprehensive orientation programme provided to staff on induction includes dignity and privacy. Interviews with staff informed an understanding of professional boundaries. Staff interviewed demonstrated an awareness of the importance of maintaining professional boundaries with residents.</p> <p>Residents interviewed stated that they have not experienced any discrimination, coercion, bullying, sexual harassment, or financial exploitation. Professional boundaries are reconfirmed through education and training sessions and staff meetings, and systems are in place to address any concerns if there was discrimination noted.</p>

<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Services are provided at Summerset Wigram that adhere to the Health & Disability Services Standards (2008) and all required legislation and guidelines are adhered to. The service has implemented policies and procedures to provide assurance it is adhering to relevant standards. Policies are reviewed and approved at an organisational level. The quality programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility.</p> <p>Staff are encouraged to relative qualifications and advised when external training is available. There is access to computer and internet resources and search engines.</p> <p>The service has embedded the quality and risk management programme. There are comprehensive action plans in place, service support from a senior team and additional education and support provided for staff. The service has reviewed a number of practices and systems and as a result has improved service delivery. Following identification of medications errors a plan was implemented resulting in a marked improvement.</p> <p>The service has responded to the planned Covid-19 vaccination roll out by inviting an external speaker to communicate with staff, residents and family and answer questions of concern.</p> <p>Residents interviewed spoke very positively about the care and support provided. 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.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>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 twelve incident forms confirmed that family were informed in a timely manner when incidents occurred. Family interviewed also confirmed they were informed at all times.</p> <p>Resident/family meetings have occurred monthly. Monthly activity planners and bi-monthly newsletters are emailed or posted to families. Residents and relatives interviewed confirmed that the care centre manager and the village manager are readily available and helpful. The regional quality manager interviewed also stated that the managers discuss how they can improve resident outcomes on a regular basis.</p> <p>Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The service has policies and procedures available for access to interpreter services for residents (and their family). If residents or family/whānau have difficulty with written or spoken English, the interpreter services are made available through the district health board with phone numbers identified in policy. There are staff on site who speak a range of languages including Filipino, and Indian dialects. There are no residents currently requiring the use of interpreting services.</p>

<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Summerset Wigram is certified to provide rest home and hospital (medical and geriatric) levels of care for up to 72 residents. There are 52 dual-purpose beds in the care centre on level one (inclusive of three double rooms for couples) and 53 serviced apartments across the ground floor and second floor certified to provide rest home level care for up to 20 residents. On the day of the audit, there were 58 residents in total - 22 residents at rest home level (including 12 in the serviced apartments) care and 36 residents at hospital level including one on a long-term support - chronic health contract (LTS-CHC) and one on an end of life contract. All others except one are funded through the Age-Related Care Contract (ARRC). One resident is private paying. All residents' rooms in the care facility are identified as dual-purpose.</p> <p>A village manager (VM) is responsible for the retirement village. The VM was appointed in March 2021 and has a background in human resource management. The village manager who is new to the aged care industry had a comprehensive orientation and stated that support from head office is readily available. She is supported by a care centre manager (registered nurse with a current annual practicing certificate) who was appointed to the position in February 2021. The care centre manager was previously the clinical nurse leader at the facility in 2020 and prior to this worked as an RN in aged care. The new management team are supported by a regional quality manager.</p> <p>Summerset group has a well-established organisational structure. Each of the Summerset facilities throughout New Zealand is supported by this structure. The regional quality manager supported the team on the day of audit and there are managers meetings weekly. The Summerset group has a comprehensive suite of policies and procedures, which guides staff in the provision of care and services. The Summerset Group Limited Board of Directors have overall financial and governance responsibility and there is a company strategic business plan in place. Summerset Wigram has a site-specific 2021 business plan and goals that has been reviewed quarterly. The philosophy, vision and values of the organisation are documented and able to be articulated by staff when interviewed.</p> <p>The managers had all attended at least eight hours of leadership professional development and/or clinical training relevant to the role.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the</p>	FA	<p>The village manager is responsible for the administrative functions of the facility and the care centre manager is responsible for operational management of the service and provides oversight of clinical care. The office manager would work with the care centre manager to relieve for the village manager if they were on leave and the clinical nurse leader would relieve for the care centre manager when away.</p>

provision of timely, appropriate, and safe services to consumers.		
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>There is an established quality and risk management system. There are policies and procedures being implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed on a regular basis. The content of policy and procedures are detailed to allow effective implementation by staff.</p> <p>The Summerset group has a quality assurance framework 2021 calendar. The calendar schedules the training, meetings, and audit requirements for the month.</p> <p>The annual residents/relatives survey for the service was last completed during 2020. The survey results showed a high level of satisfaction in all areas. A slight overall decrease in satisfaction is related to the effects of the Covid lockdown. The survey identified opportunities for improvement around communication which were documented and actioned. The 2020 annual residents/relatives survey reports overall 98.2% feedback of resident satisfaction being good or very good.</p> <p>There is a meeting schedule that includes monthly meetings as follows: quality improvement; caregiver; registered nurse; activities and resident meetings. The monthly quality and monthly care staff meetings include discussion about clinical indicators (eg, incident trends, infection rates). Infection control and restraint meetings have occurred monthly as part of the RN meetings. There is also a weekly management meeting.</p> <p>The service is implementing an internal audit programme that includes aspects of clinical care. Issues arising from internal audits are developed into corrective action plans with evidence of resolution of issues as these are identified. Monthly and annual analysis of results is completed and provided across the organisation. There are monthly accident/incident benchmarking reports completed by the care centre manager that break down the data collected across the rest home and hospital with this compared to other Summerset services of similar size and composition. Infection control is also included as part of benchmarking across the organisation. Health and safety internal audits are completed.</p> <p>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).</p>

		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. The service has implemented a number of initiatives to further reduce the number and the impact of falls.
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Incident and accident data is being collected and analysed. A review of twelve incident/accident forms identified they were all fully completed, including follow-up by a registered nurse and that family had been notified. Post-falls assessments included neurological observations for unwitnessed falls and were completed as per policy. Near misses are also reported through the incident reporting system.</p> <p>The incident reporting policy includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Post incident and accident review was noted to be very thorough with comprehensive RN review as well as root cause analysis for more serious incidents. Root cause analysis reviews included: one section 31 notification for pressure injuries, and non-section 31 issues such as (but not limited to); six resident falls, one fracture, eight medication issues, and one aggressive episode. The reviews all included an action plan; all of which had been evaluated and signed off. Corrective actions identify contributing factors, planned actions, responsibilities and staff communication and involvement. A corrective action for medication errors resulted in significant improvement.</p> <p>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.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are human resources policies to support recruitment practices. Nine staff files (one care centre manager, one diversional therapist, two registered nurses, three caregivers, a property manager and a housekeeper) were reviewed and all had relevant documentation relating to employment.</p> <p>Performance appraisals have been completed annually. Copies of annual practising certificates are on file and a review confirmed that these were current including RNs and external providers requiring these.</p> <p>The service has a comprehensive role specific 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 into the service. The orientation programme includes a buddy system with the new staff member working alongside an experienced care staff member for five days. Care staff complete competencies as part of orientation relevant to their role. Two new staff interviewed confirmed that they had a relevant and comprehensive orientation.</p> <p>There is an annual education plan in place. The 2020 and 2021 education plan has been implemented and staff stated that this is relevant to their role. A competency programme is in place with different requirements</p>

		<p>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. Staff are encouraged to complete New Zealand Qualification Authority (NZQA) qualifications. Currently there are 12 caregivers with level 3 and nine with level 4.</p> <p>In-service education is delivered at group training sessions. The service has eleven RNs (including the care centre manager and clinical nurse leader) and six trained in interRAI. RNs complete learning through an online system and can attend external training at the local DHB or training institutes.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There is an acuity and clinical staffing ratio policy in place that includes a documented rationale for staffing the service. A staff availability list ensures that staff sickness and vacant shifts are covered, and a review of rosters for a two-week period confirmed that staff are replaced when on leave. The care centre manager and clinical nurse leader manager are registered nurses, work full time Monday to Friday and share clinical on-call responsibilities on a monthly rotation. The village manager is on call for facility concerns and the property manager is available after hours as required.</p> <p>The care centre currently has 46 of a potential 52 residents. Two RNs or one RN and an EN are rostered on morning and afternoon shifts. Two RNs are rostered on three nights per week Saturday to Monday and one RN works on the other four nights. The RNs are also responsible for the rest home residents in the apartments.</p> <p>The care centres rosters eight care staff on morning shift (four long and four short). Seven care staff on afternoon shifts (four long and three short) and two care staff on nights.</p> <p>The service apartments have their own roster (currently 12 rest home residents). The apartments roster two care staff on mornings (both full shifts) two on afternoon (one long and one short) and one on night shift.</p> <p>Staff interviewed stated that there is adequate staffing to manage their workload. When staff are absent, and a replacement cannot be found from the current staff, agency staff are used. The village manager stated that staff can increase with acuity and/or resident numbers.</p> <p>Residents interviewed confirmed that there are sufficient staff on site at all times and staff are approachable, competent, and friendly. Staff interviewed also confirmed there was adequate staff on all shifts and unplanned leave was always covered.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p>	FA	<p>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 care plan is also developed in this time. Personal resident information is kept confidential and cannot be viewed by other</p>

Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.		<p>residents or members of the public. Residents' files are protected from unauthorised access by being held in a secure room. Electronic records are password protected. Archived records are secure in separate locked areas.</p> <p>Residents' files demonstrated service integration. Entries are legible, dated, timed, and signed by the relevant caregiver or nurse, including designation.</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>	FA	<p>All residents have a needs assessment completed prior to entry that identifies the level of care required. The care centre manager screens all potential enquiries to ensure the service can meet the required level of care and specific needs of the resident. A welcome pack provides relevant information regarding the service and care provided and includes (but not limited to); information about the service, extra services available (not funded), samples of the menu and activities planner. 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 ARC contract.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>There is an exit, discharge and transfer policy that describes guidelines for death, discharge, transfer, documentation and follow-up. All relevant information is documented and communicated to the receiving health provider or service. The service uses the 'yellow envelope' transfer system which includes all the required documentation and there is a discharge checklist for DHB use. One resident file reviewed evidenced the transfer process including notifying the family, and the transfer documents completed were scanned onto the electronic resident's file. Contact with the hospital and family during the resident's hospital stay were documented.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>There are medicine management policies and procedures that align with recognised standards and guidelines for safe medicine management in accordance with current guidelines. The RNs, ENs and senior caregivers are responsible for the administration of medications and have completed medication competencies and annual medication education. The RNs have completed syringe driver competencies. All medications (for the care centre and serviced apartment rest home residents) are stored safely in the one main medication room in the care centre.</p> <p>Regular medications are delivered in robotic rolls and were evidenced to be checked on delivery with any discrepancies fed back to the supplying pharmacy. The medication fridge and medication room temperature are monitored weekly and were within acceptable ranges.</p>

		<p>Sixteen resident medication charts on the electronic medication system were reviewed. The medication charts had photograph identification and allergy status recorded. Staff recorded the time, date and effectiveness of 'as required' medications. All 'as required' medications had an indication for use. All medication charts had been reviewed by the GP three-monthly.</p> <p>There were 10 self-medicating residents on the day of the audit (five in the serviced apartments, three rest home and two hospital), a sample of three files reviewed evidenced competencies had been completed and reviewed by the GP. Medications are stored in a locked drawer and monitoring is completed as required. The medication chart identified the self-administering medications. All eye drops sighted in the two trolleys had been dated on opening.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The service has a contracted company for the provision of all meals for the café and the care centre. Meals are transported from the kitchen on the ground floor to the care centre on the first floor in pre-heated hot boxes. Food is transferred to reheated bain-maries and served to residents in the dining room by staff. A tray service is provided to residents who dine in their rooms.</p> <p>There are four qualified chefs and three kitchenhands in the kitchen team, all have completed food safety training. The kitchen is open from 8 am to 6.30 pm. Nutritious snacks are available in the care centre when the kitchen is closed. Caregivers prepare and serve breakfast. There is a 12-week rotating menu in place which has been reviewed by a dietitian. Alternatives are provided, and special diets are accommodated.</p> <p>The chef receives a dietary profile for each resident. Resident likes/dislikes and allergies are known and accommodated with alternative meal options.</p> <p>The service has a current food control plan issued and expires in August 2021. Temperature checks are recorded of dishwasher, end-cooked food temperatures, serving temperatures, inward goods, fridge and freezer checks. Daily checklists and cleaning schedules are maintained. Staff were observed wearing correct personal protective clothing. The chemical provider completes a functional test on the dishwasher regularly.</p> <p>The National executive chef from the external catering company (interviewed) visits the residents in the dining rooms and gains feedback on the meals regularly, he also attends resident meetings (when requested). Feedback is acted on and changes made to the menu where possible. There are feedback books on dining room tables for residents to leave comments/thoughts/likes/dislikes. If any residents are particularly unhappy with the food services, the national executive chef meets with them individually, or as a group as requested.</p> <p>Residents also have the opportunity to feedback on meals through resident meetings and surveys. Residents and relatives interviewed commented positively on the meals provided.</p>

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 entry would be if the service was unable to provide the level of care required or if there were no beds available. 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 assessment including the risk assessment tools (as applicable) are developed with information received on admission, including discussion with the resident and relatives and referring agency. A suite of assessments are available on the electronic resident management system for the RNs to utilise as required. Risk assessments are reviewed six-monthly as part of the interRAI assessment. The interRAI assessment tool has been utilised six-monthly for all long-term residents under the aged residential care contract. Outcomes of risk assessment tools and interRAI assessment are used to identify the needs, supports and interventions required to meet resident goals of permanent residents with links to the long-term care plan.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	<p>The electronic care plans for long-term residents describe the individual support and interventions required to meet the resident goals. Care plans reviewed demonstrate service integration and include input from allied health practitioners. The care plans reviewed reflect the outcomes of risk assessment tools and the interRAI assessment. Care plans are electronically signed by the resident.</p> <p>The resident on the LTS-CHC contract had a long-term care plan in place with interventions individualised to the resident's current needs and reflect the resident's current level of independence. The resident on the end of life contract has recently been admitted. There are short-term care plans in place for specific needs including symptom management and comfort cares, falls and risk management.</p> <p>Short-term care plans were in use for changes in health status such as infections and wounds. These are evaluated regularly and either resolved or if an ongoing problem added to the long-term care plan. There is documented evidence of resident and relative (where appropriate) involvement in the care planning process. Residents and relatives interviewed confirmed they participate in the care planning process.</p>
Standard 1.3.6: Service Delivery/Interventions	FA	When a resident's condition changes, the RN initiates a review and if required a GP or nurse specialist consultation. There was documented evidence in the electronic resident files of family notification of any

<p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>changes to health including infections, accidents/incidents, GP visits and medication changes.</p> <p>Relatives interviewed stated their relative's needs are met and they are kept informed of any health changes. Residents interviewed stated their needs are being met.</p> <p>The wound care champion (RN) oversees the complex wound care. She is a member of the Somerset wound group who meet regularly and discuss complex wounds. The wound care champion has access to the wound care specialist services through Nurse Maude. Internal audits are completed around timeliness of wound dressing changes, timely photographs and timely access to specialists when required.</p> <p>Adequate dressing supplies were sighted. Individual electronic wound assessments, treatment plans, and ongoing wound evaluations and were in place. There were 21 wounds on the day of the audit, these included incontinence associated dermatitis, haematomas, skin tears, scratches, surgical wounds, and chronic ulcers. On the day of the audit there was one resident with two superficial stage 2 pressure injuries. Photographs and evaluations demonstrated progress to healing. There were sufficient pressure injury resources and equipment sighted including air alternating mattresses and pressure relieving cushions. The resident with the pressure injuries had pressure relieving equipment in place. Staff have received training on wound and pressure injury prevention.</p> <p>The continence champion oversees ordering and distribution of continence products according the continence assessments. Continence products are available (sighted). Resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed.</p> <p>A suite of monitoring forms is available on the electronic resident management system. Monitoring forms sighted included (but not limited to); pain, wounds, vital signs, neurological observations, weight, and food and fluid charts.</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 recreational team is made up of two diversional therapists (DTs) who coordinate and implement the integrated rest home/hospital activity programme over seven days. One diversional therapist works from Sunday to Thursday and the other works Tuesday to Friday. The monthly planner of activities and events is displayed and seen in resident rooms and on noticeboards.</p> <p>There is a recreational assessment and activity plan in place for the resident files reviewed. Each residents' recreational plan has been tailored to meet individual interests. The recreational care plans reviewed incorporated current and previous hobbies and interests, the activities plan is developed around residents' interests and abilities as able. The DTs are involved in the six-monthly review of the resident's care plan and activity plan. The residents and relatives interviewed expressed satisfaction with the programme. Residents meet on a monthly basis, the advocate visits regularly and there is a residents meeting held on the alternate months. No staff are involved in the advocates meeting and concerns/feedback is provided anonymously to</p>

		<p>the DT, and management team who follow up concerns. The kitchen manager of the contracted service also attends the residents' meetings as required and follows up on any concerns/feedback and suggestions for improvement. The DTs also complete comprehensive cultural assessments and care plans. The cultural care plans accommodate residents who identify as Māori, and other cultures. There are two monthly newsletters sent to the families informing them of upcoming events (includes the activities planner) and introduces new residents and acknowledges those who have passed away.</p> <p>The monthly planner includes (but is not limited to); newspaper reading, word games, craft, group games, housie, board games and entertainers. All activities throughout the village, and care centre are advertised on the planner, so residents can choose activities to suit their interests. The DT visits residents each morning to remind them of what is on for the day to assist residents to plan their day.</p> <p>Events and themes are celebrated with resident and staff participation such as Melbourne Cup, Mother's Day, Father's Day, Easter and Christmas. The DT reported that sign language week is coming up, and residents and staff will have the opportunity to learn how to use sign language. Community visitors include pre-school children, entertainers, church groups and pet therapy visits. There is a van which can accommodate residents with wheelchairs. Residents go to choir practice in the community, there is also a 'house' choir which residents from all levels of care attend. Volunteers are a big part of Summerset at Wigram. Volunteers assist residents with hearing aid cleaning, group games, one-on-one sessions with residents, and assisting with morning tea.</p> <p>One-on-one contact is made daily with residents who are unable to or choose not to participate in group activities. Pampering and hand and nail care, foot spas, chats and reminiscing, flower arranging, activities were included for one-on-one time and a volunteer visits residents regularly. The service has an IMMU cushion device which plays soft calming music. The DTs have sourced a natural calming spray which is sprayed onto the cushion, residents can either have the device beside them or they can hug the device. This is used for reducing challenging behaviours and anxiety in residents. Large 'adult' jigsaws have been sourced for residents with poor dexterity and sight to use.</p> <p>Summerset at Wigram have exceeded the standard around activities.</p>
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	<p>Written evaluations for long-term residents were completed six-monthly. Relatives are invited to attend the multi-disciplinary (MDT) review and asked for input if they are unable to attend. There is evidence of resident and relative (where appropriate) involvement in the review of long-term resident care plans. The resident or relative sign the care plan acknowledgement form around post admission (once the first care plan has been developed) and six monthly thereafter. The multidisciplinary (MDT) team including the GP, caregivers and other health professional's involvement in the resident's care are asked for input. Goals of care are evaluated, and changes are made to the care plan where goals have not been met or new goals are added.</p>

		Short-term care plans sighted have been evaluated by the RN. The GP completes three monthly reviews.
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Medical and specialist referrals are made by the GP. The registered nurses refer to nurse specialists including the Nurse Maude service for palliative care and wound care, and mental health services for older people. The dietitian, physiotherapist and podiatrist visit the facility regularly.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Safety datasheets and product sheets were readily accessible for staff. Chemicals were stored safely throughout the facility. Relevant staff have completed chemical safety training. Personal protective clothing was available for staff and seen to be worn by staff when carrying out their duties on the day of audit.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>Summerset at Wigram is a three-level facility. On the ground floor, there are service areas, café and serviced care apartments. There are also serviced apartments on level two. On level one, the care centre includes 49 rest home and hospital level rooms (all dual-purpose). Three of the rooms have been assessed as suitable for couples (double rooms). The service could have 52 residents on this floor.</p> <p>The building has a current building warrant of fitness that expires on 1 August 2021. There is a full-time property manager of the care centre and villas (also available on-call). Maintenance requests for repairs are logged onto the online system where they are actioned and signed off when completed. There are preferred contractors available 24 hours. Monthly planned maintenance duties are set by head office. These include resident related and environmental planned maintenance and signed off when completed. All electrical equipment has been tested and tagged annually. Clinical equipment has had functional checks/calibration</p>

		<p>annually. Hot water temperatures have been tested and recorded monthly with readings below 45 degrees Celsius.</p> <p>Corridors are wide in all areas to allow residents using mobility aids to move around safely. There is safe access to all communal areas and outdoor areas. There is one lift and stairwells between floors. The lift is large enough for mobility equipment including a stretcher. Outdoor areas provide seating and shade and are well maintained.</p> <p>The caregivers (interviewed) stated they have all the equipment required to safely 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>	FA	<p>The majority of rooms have full ensuite facilities. Ten rooms have shared ensuite facilities. There are mobility bathrooms/toilets near rooms that do not have an ensuite. There are adequate numbers of toilets and showers with access to a hand basin and paper towels. There are communal mobility bathrooms available in each wing and close to lounge/communal areas. The serviced apartments include a bathroom, kitchen and dining/lounge area.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Residents rooms are spacious and allow care to be provided and for the safe use and manoeuvring of mobility aids. Residents rooms viewed on the tour of the facility were personalised to residents' taste. Residents interviewed said they were able to furnish their rooms with their own adornments. Mobility aids can be managed in ensembles and communal toilets and bathrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment,</p>	FA	<p>There is a café, dining room and large lounge area utilised mainly by residents from the village and service apartments on the ground floor. All residents and/or relatives can use the café dining and seating area. On level one (care centre), there is a kitchenette, large dining area and large open plan lounge area which is</p>

<p>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>mainly used for activities. There are quiet lounge/family rooms and there are seating areas along the corridors to allow residents to rest.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. There is a large laundry area which has a dirty to clean work flow with an entry and exit door. All linen and residents personal clothing are laundered on site. Data sheets for chemical usage and personal protective equipment was available in the laundry. The laundry assistant interviewed was knowledgeable around infection control procedures.</p> <p>There are dedicated housekeeping staff on duty seven days a week. The housekeeper interviewed was knowledgeable around infection control and described ongoing cleaning duties as a result of Covid-19. Both the housekeeping and laundry staff have attended training on chemical safety. Cleaning trolleys sighted were well equipped and are kept in designated locked cupboards when not in use. External (chemical provider) and internal audits monitor the effectiveness of laundry and cleaning processes. Residents 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>	FA	<p>There are emergency and disaster manuals to guide staff in managing emergencies and disasters. Emergencies, first aid and CPR are included in the mandatory in-service programme. There is a first aid trained staff member on duty 24 hours. Appropriate training, information, and equipment for responding to emergencies is provided. There is an approved evacuation plan. Fire evacuations are held six-monthly, and the last drill was completed 13 May 2021. There are five well equipped civil defence cupboards at various locations throughout the facility. All civil defence cupboards are checked and restocked quarterly. There is sufficient water, food and alternative cooking in the event of an emergency. There is a generator available on site. During the tour of the facility, residents were observed to have easy access to the call bells, and residents interviewed stated their bells were answered in a timely manner. Call bell audits are carried out monthly. The facility is secured at night and can be accessed by authorised visitors by swipe card. There is a lock box at the main gates which contains a swipe key that can be accessed by emergency personnel.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And</p>	FA	<p>General living areas and resident rooms are appropriately heated and ventilated. The facility is heated with heat pumps in corridors and living areas with ceiling heaters in resident rooms. All rooms have external</p>

<p>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>windows with plenty of natural sunlight. Residents and relatives interviewed during the audit reported the facility is maintained at a comfortable temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The organisational infection control programme is appropriate for the size and complexity of the service. There is an infection control responsibility policy that includes responsibilities for the infection control coordinator. The infection control coordinator (RN) has been in the role since February 2020 and has a signed job description outlining the responsibilities of the role. The infection control programme is linked into the quality management system and reviewed annually at head office in consultation with the infection control committee. The facility meetings include a discussion of infection control matters.</p> <p>Visitors are asked not to visit if they are unwell. All visitors including contractors are required to declare their wellbeing (implemented during Covid-19) when signing in on the electronic register on entering the facility. Covid-19 precaution notices and hand sanitisers are available at facility entrances. Influenza vaccines are offered to residents and staff. Hand sanitisers are available throughout the facility.</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>	FA	<p>The goals of the infection control programme for 2021 include reducing urinary tract infections and eye infections by 10%. Progression towards meeting goals are reviewed at the monthly infection control meetings. The facility infection control committee is representative of the facility. The infection control coordinator attends virtual meetings with the organisational infection control coordinators and national infection control specialist. Key points from these meetings are discussed at facility meetings.</p> <p>The infection control team has access to an infection control nurse specialist at the DHB, laboratory, pharmacy, GPs and expertise within the organisation. The regional quality manager oversees infection control across the facilities.</p> <p>Covid-19 was well prepared for with red and green zones identified and weekly meetings with the national team. Staff were issued with 'fob/swipe cards' to enter the facility. Entries were locked to visitors; staff were allocated a designated entry. Staff continue to be encouraged to change into their uniforms at work. A Covid resource folder is easily accessible for staff to access guidelines if the lockdown levels change out of business hours.</p>

<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>Policies and procedures are developed and reviewed at head office in consultation with infection control coordinators. All policies/procedures have been updated to include Covid-19. Policies are available to all staff, and staff are notified of any new/reviewed policies and are required to read and sign for these.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control coordinator is responsible for coordinating and providing education and training to staff. The infection control coordinator has completed online training around infection control and is a member of the New Zealand nurses' organisation (NZNO) infection control group. The monthly virtual organisational meetings provides the opportunity to present case studies.</p> <p>The induction package includes specific training around handwashing competencies and standard precautions. Ongoing training occurs annually as part of the training calendar set at head office. Extra training was provided in 2020 for refreshers around hand washing, donning and doffing personal protective equipment, standards precautions and isolation procedures.</p> <p>Resident education occurs as part of providing daily cares. Care plans can include ways to assist staff in ensuring this occurs.</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</p>	CI	<p>The infection control surveillance policy includes a surveillance procedure, process for detection of infection, infections under surveillance, outbreaks and quality and risk management. Infection events are reported, collected monthly and entered into the electronic system. The infection control coordinator provides infection control data, trends and relevant information to the infection control committee and clinical/quality meetings. Meeting minutes are available to staff who read and sign the reading form. The facility is benchmarked against other Summerset facilities of similar size and benchmarking results are fed back to the infection control coordinator and used to identify areas for improvement. Improvements are identified and analysed</p>

infection control programme.		<p>with corrective actions developed and followed up. Additional education is provided at handovers where upward trends for infections have been identified. Reports and graphs are available in the staffroom. There was one respiratory outbreak in September 2020, which was well documented, notified to authorities in a timely manner and a debrief meeting was held. Corrective actions were implemented around learnings from the outbreak.</p> <p>The service has exceeded the standard around surveillance.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service has documented systems in place to ensure the use of restraint is actively minimised. The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.2. The use of restraint is a clinical decision made by the registered nurse in partnership with the GP. The GP completes the verification section on the specific consent verifying or not verifying the use of restraint. The relatives/EPOA will be involved in as many aspects of the decision as possible, and their input recorded on the assessment form and in the progress notes by the RN.</p> <p>There were no residents being restrained and three residents using an enabler (lap belts) during the audit. Enabler use is voluntary, and risks were well-assessed and documented in the care plan. In each case the resident continued to feel more comfortable with the enabler in place. Staff interviews, and staff records evidenced guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques.</p>

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	CI	In June 2019, the service identified the falls rate per bed night was higher than other similar Somerset facilities. The issue was identified through monthly events reporting and benchmarking. The falls prevention officer identified an opportunity to reduce the number of falls in the care centre and involved key staff in documenting a plan	The falls prevention officer decided to focus on reducing the number of falls in the care centre by implementing falls prevention initiatives specific to the residents' health care needs. A committee of 14 members including RNs, caregivers, a GP and the contract physiotherapist was formed with members representative of all roles and shifts. The committee meets monthly to review all falls events and to identify vulnerable and frequent faller residents who would benefit from a review and implementation of fall prevention initiatives. The physiotherapist reviewed at risk residents and developed individual exercise and walking programmes allocated to caregivers by shift. Additional equipment was purchased including chair and mat sensors, landing mats and perimeter mattresses. Intentional rounding provided increased supervision of specific at-risk residents. The GP was involved in prescribing Vitamin D for residents and in reducing polypharmacy which may have contributed to individual residents falls risks. Families were educated and encouraged to purchase hip protectors where these were indicated. Increased seating in public areas including hallways throughout the facility provided resting areas for residents to break longer walks. Staff education was reviewed and moving, and handling training and competencies updated. Caregiver coaches were trained to provide additional support to caregivers on shift. As a result of these improvements falls rates have evidenced an ongoing downwards trend

		to achieve their goal.	and despite occasional spikes which were attributed to acute changes in a specific resident's health the trend has continued. In 2019 seven of eight months were above 20. In 2020 three out of 12 months were above 20. For 2021 one of five months has been above 20. The lowest falls rate recorded since the initiative was implemented was in March this year where eight falls were recorded.
<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>On reflection of the 2020 resident satisfaction survey, activities ratings were slightly down. A review of the activities programme and supporting residents settle into their new home was looked at.</p>	<p>One of the diversional therapists has created a folder which is available to all new residents and relatives. The folder was created to assist residents and relatives get to know 'why' certain celebrations and commemorative days are celebrated. The folder contains a map of the facility, copies of the advocates meetings and resident meetings, along with an explanation of the importance of these meetings. There is information around when the podiatrist and the ear health services visit the facility and information around how to make an appointment and where to find when the next visit is due. There is information around how birthdays are celebrated, and residents choose whether they would like to celebrate their birthdays or not. A welcome card is signed by all staff, and residents receive a small gift. The service is now able to provide residents with a bible if they would want one. There is information around the benefits of exercises. There is also information around the 'employment' of volunteers and what the volunteers are available to do. Residents and relatives interviewed during the audit were very positive around the information in the folder and found it answered a lot of their questions.</p> <p>Activities are available to all residents throughout the complex, staff have noticed more residents joining activities in the care centre, and residents from the care centre joining the village residents in bowls and entertainment. The DTs work hard to ensure residents with an interest in the activities on offer are supported to attend. Residents from the care centre who have an interest in bowling and are no longer able to play are supported to watch the village residents play, and those who are able, play with the village residents. One resident interviewed went to see the dancers in the village in the morning and was planning to join the entertainment in the care centre in the afternoon. With the introduction of opening up all activities to all people, there has been an overall increase in attendance by residents across the service, positive feedback has been documented in resident meetings around the range of activities and residents reported activities are now much more stimulating and enjoyable.</p>
<p>Criterion 3.5.7</p> <p>Results of</p>	CI	<p>Overall surveillance data for 2019 evidenced a total of</p>	<p>Staff were refreshed on policies around infection control practices, education was held around hand hygiene, standard precautions, and infection prevention and control management. Staff were reminded at handover of residents with current infections and precautions required. The</p>

surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.		104 infections. A corrective action plan was implemented to reduce the incidence of urinary tract infections (UTI), respiratory, skin and eye infections.	<p>infection control board in the staff room was updated at least monthly and included information and graphs of infections for the month, including graphs and benchmarking. Data was discussed more in-depth at staff and clinical meetings. Short term care plans continued to be utilised for residents, GP was informed, and specimen results were monitored. The clinical staff were knowledgeable around residents with current infections and could fluently describe standard precautions and isolation practices.</p> <p>This resulted in less hospitalisation of residents with infections, less referrals required to the wound care specialists. The infection rates have reduced to 79 in 2020 and 25 year to date.</p>
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End of the report.