

Summerset Care Limited - Summerset by the Sea

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity: Summerset Care Limited

Premises audited: Summerset by the Sea

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

Dates of audit: Start date: 5 July 2021 End date: 6 July 2021

Proposed changes to current services (if any): This audit included verifying the reconfiguration relating to the conversion of 23 care centre beds into 10 serviced apartments suitable for dual purpose (rest home or hospital level of care) with two apartments (apartments 301 and 303) able to cater for two residents in each (therefore a total of 12 beds in these new serviced apartments).

This will bring the total number of dual-purpose beds in the care centre to 27; plus 20 serviced apartments at rest home level of care downstairs; and 10 newly reconfigured serviced apartments able to provide 12 beds in the upstairs area. The total number of beds will be at 59 following verification.

Total beds occupied across all premises included in the audit on the first day of the audit: 29

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Summerset by the Sea currently provides rest home and hospital level care for up to 49 residents in the care centre and up to 20 rest home residents in the serviced apartments. On the day of the audit there were 27 residents in the care centre and two rest home residents in the serviced apartments. The residents and relatives interviewed spoke positively about the care and support provided.

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

A partial provisional audit was also completed at the time of audit included verification of the reconfiguration of 23 care centre beds into 10 serviced apartments suitable for dual purpose (rest home or hospital level of care) with two apartments able to cater for two residents in each. The final total following verification at this audit will be 59 beds including 27 in the care centre and 32 beds available in 30 serviced apartments.

The service is managed by a village manager who has been in the role for five years and a care centre manager (RN) who has been in the role just over two years. The management team is supported by a regional operations manager and regional quality manager.

This audit identified areas for improvement around the complaints process, a transition plan to be ready for the move into the reconfigured serviced apartments, the quality programme, monitoring of security of the building site, and completion of the building site prior to occupancy.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Some standards applicable to this service partially attained and of low risk.
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Summerset by the Sea provides care in a way that focuses on the individual resident. There is a Māori health plan and cultural safety policy supporting practice. Cultural assessment is undertaken on admission and during the review process. The service functions in a way that complies with the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code).

Information about the Code and related services is readily available to residents and families. Policies are available that support residents' rights. Care plans accommodate the choices of residents and/or their family. A policy around managing complaints is documented. Residents and family interviewed verified ongoing involvement with the community.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Summerset by the Sea has a documented quality and risk management system. Data is collected from key components of the quality management programme. Annual resident and family surveys provide an opportunity for feedback about the service.

There are human resources policies including recruitment, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care. There is a staffing policy in place with a registered nurse on each shift.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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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 demonstrate 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 (medimap) are reviewed at least three-monthly by the general practitioner.

The diversional therapists 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.		Some standards applicable to this service partially attained and of low risk.
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The building holds a current building warrant of fitness. All internal and external areas are safe and well maintained. Areas under construction are clearly marked and are not accessible to residents. 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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Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort. There were four residents using restraint for safety reasons on the day of audit. No residents used enablers. Restraint minimisation, enabler use, and challenging behaviour training is included in the training programme.

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 Somerset head office and online DHB training via Ko Awatea. 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 Somerset facilities. There has been one respiratory outbreak since the previous audit which was appropriately managed.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	44	0	6	0	0	0
Criteria	0	92	0	9	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	Discussions with managers and staff were completed during the audit. Interviews took place with the village manager, the care centre manager, and the regional quality manager. Interviews were also held with the following staff: three caregivers, three registered nurses (RNs), one kitchen manager, kitchen assistant, property manager, project manager (building site) and diversional therapist. All care staff confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). All staff complete training around Code of Rights.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	<p>Informed consent processes are discussed with residents and families on admission. Written general and specific consents were sighted in the six resident files reviewed (three rest home and three 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 deemed incompetent to make a decision. Discussion with family members identified that the service actively involves them in decisions that affects their relative's lives.</p>

		Six resident files of long-term residents have signed admission agreements.
<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	Residents are provided with a copy of the Code of Rights and access to advocacy services 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. Code of Rights and advocacy is discussed with residents and relatives on admission to the service. Meeting minutes are displayed on the resident noticeboard. The service provides opportunities for the family/enduring power of attorney (EPOA) to be involved in decisions as evidenced in the resident files reviewed. The resident files included information on residents' family/whānau and chosen social networks.
<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	Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. Activities programmes included opportunities to attend events outside of the facility including activities of daily living, for example, shopping and attending cafés and restaurants. Interview with staff, residents and relatives informed residents are supported and encouraged to remain involved in the community and external groups. Relative and friends are encouraged to be involved with the service and care.
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	PA Low	<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 including involvement from the care centre manager for clinical concerns/complaints.</p> <p>There is a complaint register that included relevant information regarding the complaint. Documentation was expected to include acknowledgement, investigation, follow-up letters (offering advocacy) and resolution. There were four complaints lodged in 2020 and one in 2021 to date. Complaints reviewed did not all include relevant documentation required in policy and a complete record of the complaint was not retained in one instance. Complaints and concerns are discussed at the relevant facility meeting.</p> <p>A complaints procedure is provided to residents within the information pack at entry. Feedback forms are available for residents/relatives and there is a suggestion box available.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their</p>	FA	The service provides information in the welcome pack 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 were interviewed including three residents

rights.		from the rest home, five residents with hospital level of care, two family from the rest home and three with family from hospital level of care. All identified they are well informed about the Code. The Code (in English and Māori) is displayed at the main entrance of the care centre. Monthly resident meetings and the residents/relatives survey is completed and provides an opportunity to raise concerns.
<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>Staff interviewed were able to describe the procedures for maintaining confidentiality of resident records, resident's privacy, and dignity. Contact details of spiritual/religious advisors are available. Resident files included cultural and spiritual values. Residents and relatives interviewed reported that residents are able to choose to engage in activities, access community resources and are supported to attend church services. Staff were observed knocking on resident doors before entering the room.</p> <p>There is an elder abuse and neglect policy. Staff receive education and training on abuse and neglect on an annual basis. There was no evidence of any abuse and neglect observed during the audit and staff stated that there was never any evidence of abuse or neglect.</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 2020 to 2021 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. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged.</p> <p>Links are established with a local iwi kaumātua and marae (Te Rereatukahia Marae), with meetings held to establish relationships and to create a pathway for local Māori care. Plans are in place for a visit to the marae. Education on the Treaty of Waitangi has been completed (Ngai Te Rangi). The service has access to advisors at the Māori health unit at the DHB and access to cultural education courses. There were no residents who identified as Māori on the day of audit. Staff interviewed were able to describe how they would ensure they meet the cultural needs of residents identifying as Māori.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>An initial care planning meeting is carried out where the resident and/or whānau as appropriate/able are invited to be involved. Individual beliefs or 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 are invited to attend. Discussion with relatives confirmed values and beliefs are considered. Residents interviewed confirmed that staff consider their culture and values.</p>

Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	The facility has a staff code of conduct which aims to have no discrimination occurring. The registered nurses supervise staff to ensure professional practice is maintained in the service. The abuse and neglect processes cover harassment and exploitation. All residents interviewed reported that the staff respected them. Job descriptions include responsibilities of the position, ethics, advocacy, and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	<p>Residents and relatives interviewed, spoke very positively about the care and support provided. Staff have a sound understanding of principles of aged care and stated that they are supported by the village manager and care centre manager.</p> <p>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 group is undertaken (link 1.2.3.6). There is a culture of ongoing staff development with an in-service programme being implemented.</p> <p>Caregivers, once orientation has been completed, work to get level two Careerforce unit standards. There is evidence of education being supported outside of the training plan. Registered nurses are linked to the DHB professional development recognition programme (PDRP). There are implemented competencies for caregivers and registered nurses specific to their roles.</p> <p>There is good liaison and working relationship with the DHB personnel and outside organisations as needed on an individual basis. Services are provided at Summerset that adhere to the Health and Disability services standards.</p>
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	<p>Residents and family members stated they were welcomed on entry and were given time and explanation about services and procedures. Family members interviewed also stated they are informed of changes in the resident's health status and incidents/accidents as evidenced in all accidents/incidents reviewed on the electronic register. Resident/relative meetings are held monthly with an independent advocate if requested. The village manager and the care centre manager have an open-door policy with this observed to be used during the audit.</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</p>

		<p>interpreter services for residents (and their family/whānau). If residents or family/whānau have difficulty with written or spoken English, the DHB interpreter services are made available.</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>	PA Low	<p>On the day of the audit, the service currently provides care for up to 49 residents at hospital and rest home level care in the care centre and up to 20 rest home level of care residents in serviced apartments. On the day of the audit, there were 27 residents in the care centre including 12 at rest home level and 15 hospital level residents. All beds in the care centre are dual-purpose beds. There were two residents in the serviced apartments requiring rest home level of care. All residents were under the Age-Related Care contract.</p> <p>A partial provisional audit was completed as well as the certification audit. The partial provisional audit verified the reconfiguration of 23 care centre beds into 10 serviced apartments suitable for dual purpose (rest home or hospital level of care) with two apartments (apartments 301 and 303) able to cater for two residents in each (therefore a total of 12 beds in these new serviced apartments). This will bring the total number of dual-purpose beds in the care centre to 27; plus 20 service apartments at rest home level of care downstairs; and 10 newly reconfigured serviced apartments able to provide 12 dual purpose beds in the upstairs level. The total number of beds will be at 59 following verification (27 care centre and 32 serviced apartments).</p> <p>The Summerset Group Limited Board of Directors have overall financial and governance responsibility and there is a company strategic business plan in place. Summerset by the Sea has a site-specific business plan and goals that are developed in consultation with the village manager, care centre manager and regional quality manager. The Summerset by the Sea quality plan is reviewed quarterly throughout the year. The 2020 evaluation was sighted and there is a 2021 village plan in place that includes key priorities for the service. A mission statement is documented.</p> <p>The village manager (non-clinical) has been in the role for five years and has a background in human resources. The village manager attends ARC meetings, village manager meetings and related education sessions with clinical oversight provided by the care centre manager (registered nurse).</p> <p>The care centre manager (CCM) has attended at least 10 hours training in the past year relevant to their role. In November 2021, the CCM completed their PDRP with the Hawkes Bay District Hospital which acknowledged them as being senior designation nurse level. The CCM continues to be involved in the NZACA meeting in the area, has attended training with the DHB and has been involved in the infection prevention and control and Covid groups. In 2020, the CCM attended training in leadership and development through Summerset.</p> <p>The 10 serviced apartments (a wing off the care centre on level one) is expected to be opened on the 31 August 2021. A transition plan to move staff and residents into the serviced apartments when</p>

		completed is not yet documented.
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>During a temporary absence, the CCM is replaced with a senior RN who has over five years' experience in aged care. The service would also be supported by the regional quality manager as the village manager is non-clinical. The regional quality manager and regional operations manager would support the CCM if the village manager were on leave. The audit confirmed the service has operational management strategies and a quality improvement programme to minimise risk of unwanted events.</p> <p>Partial provisional: There will not be any change to delegation of duties with the opening of the serviced apartments.</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>	PA Low	<p>Summerset by the Sea is implementing an organisational 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 from head office. The content of policy and procedures are detailed to allow effective implementation by staff. Staff are required to read and sign for new/reviewed policies.</p> <p>The Summerset group has a 'clinical audit, training and compliance' calendar. The calendar schedules the training and audit requirements for the month. The village manager and care centre manager complete monthly reports confirming completion of requirements. There is a meeting schedule including monthly quality improvement meetings, staff meetings, registered nurse meetings and care staff meetings. The infection control coordinator provides a monthly report and health and safety committee meetings are held. Quality data such as infections, accidents/incidents, hazards, restraint, audit outcomes, concerns/complaints are discussed and documented in meeting minutes. Meeting minutes and quality data reports and graphs are available to all staff. Corrective action plans and re-audits are completed if audit results are less than expected. Monthly and annual analysis of results is completed; however, discussions and follow-up of issues and corrective actions are not sighted as being communicated to all staff through meetings such as the health and safety and staff meetings.</p> <p>An annual residents/relatives survey has been completed. The 2020 and 2021 surveys confirmed a high level of satisfaction with the service and the residents and family interviewed also confirmed a high level of satisfaction with the service.</p> <p>There are monthly accident/incident benchmarking reports completed by the CCM that break down the data collected across the rest home and hospital. Infection control is also included as part of benchmarking across the organisation. Data is analysed, and corrective actions are required based on</p>

		<p>benchmarking outcomes. The regional quality manager is alerted automatically through the RMSS system of any high-level accident/incidents (resident, staff and environmental).</p> <p>There is a health and safety and risk management programme in place including policies to guide practice that is generated from the national health and safety committee. The service has a health and safety officer with health and safety level 1 qualifications. The health and safety committee review incidents/accidents/hazards and near misses and provide a report to the quality improvement and health and safety committee meetings. Staff interviewed confirmed they are informed when health and safety meetings are due and have the opportunity to provide input into health and safety. Each month there is a focus on one of the golden rules of safety. All staff and contractors receive a health and safety induction.</p> <p>The hazard register has been updated to reflect risks related to the building site.</p> <p>Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.</p> <p>Partial provisional: There will not be any change to the quality and risk management programme with the opening of the serviced apartments.</p>
<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>Resident related incident reports for 2021 were reviewed including unwitnessed falls, witnessed falls, skin tears and one challenging behaviour incident. All 20 reports and corresponding resident files reviewed evidenced that appropriate clinical care has been provided following an incident and the relative had been notified. The incident reporting policy includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Data is linked to the organisation's benchmarking programme and used for comparative purposes (link 1.2.3.6). Any incident where a resident had an unwitnessed fall or a hit to their head had neurological observations completed as per policy.</p> <p>Discussions with the village manager, care centre manager and regional quality manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have not been any requirements to notify any external provider of any serious incident or accident since the last audit. The respiratory (cough and colds) outbreak was not a reportable event.</p>
<p>Standard 1.2.7: Human Resource Management</p>	FA	<p>There are human resources policies to support recruitment practices. A list of RN and allied health practising certificates is maintained. Eight staff files (one care centre manager, three RNs, two caregivers, one diversional therapist and one housekeeper) were reviewed and all had relevant</p>

<p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>documentation relating to employment.</p> <p>The service has an orientation programme in place for each role 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 adequately orientated to the service. Caregivers are level two of Careerforce once they have completed their orientation booklet.</p> <p>There is an annual education plan that is outlined on the 'clinical audit, training and compliance calendar'. The plan has been completed for 2021 to date. There are good attendance numbers and staff who do not attend are required to read the education material and sign the reading sheet. The training programme is flexible enough to add additional in-services relevant to the service. The service has an educational goal around providing palliative care training. External education is also provided, and RNs are linked to the PDRP (professional development recognition programme) at the DHB. All performance appraisals had been completed annually.</p> <p>There are six RNs and two have completed interRAI training. The CCM has also completed interRAI training.</p> <p>Caregivers have completed the following levels for Careerforce: seven at level 2, five at level 3, six at level 4.</p> <p>A competency programme is in place with different requirements according to work type (eg, caregivers, registered nurse, and kitchen). Core competencies are completed, and a record of completion is maintained on staff files and online. The contracted physiotherapist completes safe manual handling and hoist training for staff.</p> <p>Partial Provisional: There are no expected changes to the orientation and training programme as a result of the newly appointed serviced apartments.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The village manager and care centre manager work 40 hours per week (Monday to Friday) and are available on call for any emergency issues or clinical support. The service provides a 24-hour RN.</p> <p>In the care centre, there are three caregivers on a full shift in the morning and one on duty for three hours; two caregivers on a full shift and two on a short shift in the afternoon; and two caregivers overnight on a full shift.</p> <p>The two residents in the serviced apartments were both able to ring their call bell. There is a caregiver on duty from 8 am to 1 pm to support the residents, then a designated caregiver from the care centre provides support for the rest of the 24-hour period. There is a registered nurse on each shift. A senior caregiver with a first aid certificate is designated to attend to village callouts. The registered nurse was confirmed as not being able to leave the care centre site. A review of the 13 callouts from March 2020</p>

		<p>to date indicated that there were 20 callouts requiring a low level of intervention.</p> <p>Staffing levels and skills mix policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery. Relatives and residents confirmed there were sufficient staff on duty.</p> <p>Partial Provisional: There are no expected changes to staffing levels as a result of the newly appointed serviced apartments as the service has over capacity with staffing numbers.</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>	FA	<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 electronic record. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Electronic resident files are password protected from unauthorised access. Individual resident files demonstrated service integration.</p>
<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>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 screens 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 six 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 senior registered nurses are available to answer any questions regarding the admission process.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated</p>	FA	<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 information was available in resident records of those with previous hospital</p>

transition, exit, discharge, or transfer from services.		admissions. One file reviewed was of a resident who had been transferred to hospital acutely post an episode of epistaxis. 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>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 comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were four residents self-administering on the day of audit. The residents each had a current assessment, safe storage of their medication within their room and a self-medicating resident 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 who administer and/or countersign for 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.</p> <p>Registered nurses interviewed could describe their role regarding medication administration. 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. Twelve 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>Partial Provisional: Residents' medication including controlled drugs, will be stored in the care centre medication room trolley and controlled drug safe as required. Residents' medication prescriptions and profiles will be accessed through the Medimap medication system. Registered nurses will be responsible for medication administration in the newly reconfigured serviced apartments providing rest home or hospital level of care.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food,</p>	FA	The meals at Summerset by the Sea 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, expiring 28 June 2022. There is a four-weekly seasonal menu that is designed and reviewed by a registered dietitian at an organisational level. The kitchen manager receives resident dietary information from the RNs and is

fluids and nutritional needs are met where this service is a component of service delivery.		<p>notified of any changes to dietary requirements (vegetarian, pureed foods) or of any residents with weight loss. The kitchen manager (interviewed) is 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 using an electronic temperature management system. Food temperatures are checked at 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</p> <p>The residents interviewed were very satisfied with the standard of 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>Partial Provisional: The reconfiguration of the 23 care beds into 10 serviced apartments will have no impact upon food services as it operates as at the previous (higher) occupancy level currently. The residents will use a new dining area with food being delivered to the kitchenette/servery in heated scan boxes which the service already has on site.</p> <p>The apartments are on the same floor as the care centre, and this is current practice for the care centre dining area. It is the resident's choice whether they would like to eat in one of the dining areas or their own room.</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</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</p>

are gathered and recorded in a timely manner.		<p>discharge summaries, allied health professionals and in consultation with the resident/relatives.</p> <p>The service uses VCare and interRAI assessments for all residents. 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 consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Six resident files were reviewed across a range of conditions including (but not limited to) recurrent falls, diabetes, restraint, and chronic wounds. 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 care professionals, including the podiatrist, dietitian, vascular specialist 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.</p> <p>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>	FA	<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 13 ongoing wounds including four skin tears, three minor lesions, three chronic ulcers, two ingrown toenails and one grade 1 pressure injury (facility acquired). There was</p>

		<p>evidence of wound nurse specialist involvement in chronic wound management.</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 very 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>	FA	<p>The service employs two diversional therapists 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 recreational 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, a ukulele group and pet therapy. The activity team provide a range of activities which include (but are not limited to) bar exercises, walks outside, crafts, games, quizzes, entertainers, weekly happy hour and bingo.</p> <p>The activity team are involved in the admission process, completing the initial activities assessment, and have input into 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.</p> <p>Partial Provisional: The reconfiguration of the 23 care beds to 10 serviced apartments (potentially 12</p>

		residents) will have no impact upon the activities programme as it operates as at the previous (higher) occupancy level currently.
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Five of the six resident care plans reviewed had been evaluated by the registered nurses six-monthly or earlier if there was a change in health status. One hospital resident had not been in the service for six months at the time of audit. 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, the diversional therapists, 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. Progression towards meeting goals is documented.</p>
<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>Summerset by the Sea 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 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 gave 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>	FA	<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>Partial Provisional: Summerset by the Sea has waste and hazard substance management, and chemical storage policies, procedures and facilities in place that are able to manage the additional requirements</p>

		for residents within the 10 serviced apartments (link 1.4.2.1).
<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>	PA Low	<p>The building holds a current building warrant of fitness, which expires on 21 April 2022. Request forms for repairs are available for residents and staff, these then being entered on to the 'Tech1' property management system and signed off electronically as repairs are completed. There is a fulltime property manager who, with the property team, carries out the 52-week planned maintenance programme. The village manager and property manager are 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 April 2022. All electrical equipment has been tested and tagged and is next due in October 2021. 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>Partial Provisional: The 10 serviced apartments with request for configuration of services to include dual service beds which are in the same building as the current care services, and the environment was determined to be safe and appropriate for hospital level care subject to completion of partial attainments prior to occupancy. There is adequate equipment and amenities in place to provide hospital care within the apartments. There are ten apartments located in one wing branching from the main care centre, on the same floor.</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</p>	FA	<p>All bedrooms apart from six have ensembles. The six share three bathrooms between them which are located nearby in the corridor. 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</p>

requirements.		<p>times.</p> <p>Partial Provisional: The 10 serviced apartments have ensembles with a toilet included. The ensembles are sufficiently spacious for disabled access (link 1.4.4.1). They are fitted with an emergency call bell which provides an audible and visual alert to staff (link 1.4.7.5). There are adequate communal toilets available. There are toilets near communal areas with privacy locks.</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>	PA Low	<p>All resident rooms are 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>Partial Provisional: The bedrooms and lounge areas in the serviced apartments have adequate room to safely manoeuvre mobility aids and hoists. Each room is fitted with call bells that link to the existing nurse call system and residents have call bell pendants (link 1.4.7.5).</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>There are numerous spacious communal areas throughout the facility. Activities as observed on the day of the audit are held in the lounges. The lounges are large enough so there is no impact on other residents who are not involved in activities. The arrangement of seating and space allows both individual and group activities to occur. There were smaller lounges/family rooms, equipped with a kitchenette where residents who prefer quieter activities or family/visitors may sit and make a cup of tea/coffee. The dining rooms are spacious.</p> <p>Partial Provisional: Each of the 10 serviced apartments contain an open plan lounge and dining area with ample room for accessibility to safely manoeuvre mobility aids (link 1.4.2.1). They connect by wide hallways to the communal facilities. There are communal lounge areas available through the facility.</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</p>	FA	<p>The service has a comprehensive cleaning and laundry manual to guide staff in the safe and efficient use of laundry and cleaning services. Cleaning and laundry services are monitored through the internal auditing system. Safety data sheets are available in both the laundry and cleaners' rooms. All chemicals are stored in a locked cupboard. There is appropriate personal protective wear readily available. There are dedicated laundry staff and cleaners on duty seven days a week. All laundry is undertaken on site.</p>

being provided.		<p>The laundry is spacious and well organised and divided into a 'dirty and clean' area with separate entry and exit. The laundry is located on the ground floor and clean laundry is transported in covered trolleys by lift to the care centre. All dirty laundry is sorted into bags and sent via the chute to the dirty area in the laundry for washing.</p> <p>Cleaning trolleys sighted were well equipped and are kept in designated locked areas when not in use. There are locked chemical boxes securely fixed to the cleaning trolley.</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>Partial Provisional: Summerset by the Sea has laundry and cleaning facilities that are designed to manage additional laundry and cleaning requirements for residents within the 10 serviced apartments (link 1.4.2.1).</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>	PA Low	<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. Summerset by the sea has an approved fire evacuation plan and fire drills occur six-monthly. Smoke alarms, sprinkler system and exit signs are in place. The service has alternative cooking facilities (barbeque) available in the event of a power failure. There are 3x 1000 litre tanks and stored bottled water for use in an emergency. The service holds at least three days of food storage. Emergency power is used for lighting and call bells for up to two hours with torches readily available. A generator is able to be accessed if necessary.</p> <p>Call bells were evident in resident's rooms, lounge areas, and toilets/bathrooms.</p> <p>The facility is secured at night. The village gates are locked at night with access to the emergency services. There are security cameras at entry and exit points.</p> <p>Partial Provisional: The call bell system is available for all residents living at Summerset by the Sea; however this is not operational yet in the building site. The apartments are part of the same building as the care centre and come under the emergency management plan.</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</p>	FA	<p>All bedrooms and communal areas are appropriately heated and have ample natural light and ventilation. The facility utilises a combination of reticulated hot air heating and heat pumps, all of which are thermostatically controlled. Staff and residents interviewed stated that these are 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>

that is maintained at a safe and comfortable temperature.		Partial Provisional: The 10 serviced apartments have adequate natural light, ventilation and appropriate heating (link 1.4.2.1).
<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 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 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. The majority of residents and staff have received two doses of the Pfizer Covid-19 vaccine. The facility has a Covid/Pandemic plan in place and appropriate amounts of PPE on hand to last for at least two weeks in case of a further lockdown. During Covid the service held regular virtual meetings with the DHB Covid preparedness team to check policies, procedures and service readiness. As part of the pandemic response the service implemented mandatory staff handwashing on entry to the facility, and although this is no longer mandatory, staff are strongly encouraged to continue this practice. Covid scanning and/or manual sign in is mandatory. Covid-19 education has been provided for all staff, including hand hygiene, donning and doffing, and use of PPE.</p> <p>Residents are offered the influenza vaccine annually. There was one respiratory outbreak in March 2020, affecting two residents and four staff which was appropriately managed. This outbreak was not required to be reported to the public health team.</p> <p>Partial Provisional: The infection control team consists of the ICC, care centre manager, and representatives from maintenance, care and household staff. The infection control team will remain in place with the reconfiguration of the existing rooms into 10 serviced apartments providing dual service and remains appropriate to the size and scope of the service provided.</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</p>	FA	<p>There are adequate resources to implement the infection control programme at Summerset by the Sea. The ICC liaises with the infection control committee who meet monthly and as required (more frequently in case of Covid level change). 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</p>

meet the needs of the organisation.		antibiotics. Overall effectiveness of the programme is monitored by Somerset head office.
<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>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 Somerset head office.</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 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 Somerset ILearn intranet with resources, guidelines best practice, education packages and group benchmarking. The ICO 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 Somerset 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</p>

		<p>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>The service has policies and procedures to support of the use of enablers and restraints. The policy meets the intent of the restraint minimisation standards. A senior registered nurse is identified as the restraint coordinator with a job description which defines the responsibility of the role.</p> <p>There are four residents using restraint, that is, three residents with bedrails and one with a bedrail and chair brief. There were no residents using an enabler on the day of audit. The restraint coordinator stated that any use of an enabler would be voluntary. Staff have had training around use of restraint and management of challenging behaviour in 2021.</p> <p>Partial Provisional: There are no expected changes to the use of restraint or enablers as a result of the newly appointed serviced apartments.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>The role and responsibility for the restraint coordinator is included in the restraint policy and in the job description. Registered nurses complete a restraint self-learning package on orientation and ongoing education is included in the education planner. Care staff also complete self-learning packages. The restraint committee (care centre manager, restraint coordinator, and three caregivers) approve the use of restraints.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>The restraint coordinator undertakes restraint assessments in consultation with the RNs, GP and in partnership with the family/whānau. Restraint assessments are based on information in the care plan, resident discussions and on observations of the staff. There is a restraint assessment tool available, which is completed for residents requiring an approved restraint for safety. Assessments reviewed for two residents using bedrails showed that all were completed as required and to the level of detail required for the individual residents.</p>

<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. Monitoring and observation is included in the restraint policy. There are approved restraints documented in the policy. The restraint coordinator is responsible for ensuring all restraint documentation is completed. The approval process includes ensuring the environment is appropriate and safe.</p> <p>Restraint authorisation is in consultation/partnership with the resident (as appropriate) or whānau/EPOA, GP and the facility restraint coordinator. The risks identified were documented in the care plans for two residents on restraint. The frequency of monitoring was documented in the care plans.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations occur three-monthly as part of the ongoing reassessment for the resident on the restraint register, and as part of the care plan and GP review.</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>	FA	<p>Restraint use in the facility is evaluated in the monthly RN team meeting and annually. The restraint coordinator provides monthly restraint and enabler reports to the regional manager. Policies are reviewed by the policy review group at head office. Internal restraint audits identify any areas for improvement. Restraint is discussed at clinical meetings and at handovers. There have been no incidents relating to restraint use.</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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p>	PA Low	<p>There is a documented complaints process that includes reference to timeframes to acknowledge and investigate a complaint as per the Code and the policy. Three complaints were reviewed during the audit. An email or letter to confirm acknowledgement of a complaint was not sent within five days to two of the three complainants. A record of the actual complaint in one case was not on record and there was no evidence that the complaint had been resolved.</p> <p>One resident interviewed stated that they had complained a week prior to the audit and on the day of the audit, however these complaints had not been recorded on the register. Seven of the eight residents were interviewed, and all five family members interviewed stated that they had not had to lodge a complaint.</p>	<p>i) Timeframes for acknowledging that a complaint has been received was not on record in two of the three complaints reviewed.</p> <p>ii) A record of the complaint and investigation of one complaint was not</p>	<p>i) Ensure that timeframes for acknowledging that a complaint has been received are met.</p> <p>ii) Retain a record of the complaint and any investigation of a complaint including evidence of resolution and</p>

			retained on record.	outcome for the complainant. 180 days
<p>Criterion 1.2.1.1</p> <p>The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.</p>	PA Low	A transition plan to guide the opening of the reconfigured building has not yet been put in place.	A transition plan to guide the opening of the reconfigured building has not yet been put in place.	<p>Develop a transition plan to guide the opening of the reconfigured building.</p> <p>Prior to occupancy days</p>
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	There are meetings held to give opportunities for staff to discuss data and issues. The staff and health and safety meetings do not always show evidence of discussion or sign off of resolution. For example, there was little evidence of discussion of audit results.	The staff and health and safety meetings do not always show evidence of discussion or sign off, of resolution of issues when raised.	<p>Ensure that there are opportunities to discuss data and issues when these are raised through the quality and risk management programme.</p> <p>180 days</p>
<p>Criterion 1.2.3.9</p> <p>Actual and potential risks are identified, documented and where appropriate communicated to consumers, their</p>	PA Low	The building site was not secure and residents, visitors or unauthorised people were at risk of wandering into the site during the audit. One exit had a saw horse in front with a sign stating that the site was not to be entered, however	Partial Provisional: The building site was not	The service should continue to monitor

<p>family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:</p> <p>(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;</p> <p>(b) A process that addresses/treats the risks associated with service provision is developed and implemented.</p>		<p>the door was not secured. There was also a set of stairs at the far end of the site that led to the outside area. The door downstairs was locked at night but there was no sign to state that the stairs should not be used to gain access to the building site. The managers stated that the Council had said the doors were not able to be locked as the site was a fire exit for residents should there be a fire in the level one area. The only other exit from the care centre was by lifts (non-operational if there was a fire) and a set of stairs beside the lift.</p> <p>The service responded to the issues identified on the day of audit and the following was put in place: i) a static guard put in place to watch all exits once builders left the site; ii) the risk management plan was updated to include the response in the event of an emergency; iii) photos provided to the auditors confirmed that actions had been put in place.</p>	<p>secure, and residents, visitors or unauthorised people were at risk of wandering into the site which has equipment, an open lift shaft, with building in progress on the day of audit.</p>	<p>security and safety of residents, staff and visitors until the building site is handed over to the service once completed.</p> <p>Prior to occupancy days</p>
<p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p>	PA Low	<p>Cabling for power, heating and lighting are in place for areas under construction, however these are not yet operational. Building, including wall panels, ceiling panels and cabinetry is in progress, however these are not yet completed. Equipment and furniture for resident use is available, however these are not yet in their specific areas due to ongoing construction. An elevator shaft is in situ; however, the elevator has not yet been delivered and fitted. The building has a current building warrant of fitness; however, the new serviced apartment area does not yet have a code of compliance.</p>	<p>Partial Provisional:</p> <p>i) Power, heating and lighting are not available in the reconfigured area.</p> <p>ii) The building of the serviced apartments is not yet completed to a standard suitable for resident occupation.</p>	<p>i) Ensure power, heating and lighting are operational.</p> <p>ii) Ensure the building work, including walls, ceilings and cabinetry are fully completed.</p> <p>iii) Ensure each area has the appropriate equipment</p>

			<p>iii) Equipment and furniture are not in place and operational in its specific area (eg, kitchenette, sluice, bathrooms, communal areas).</p> <p>iv) There is no elevator fitted at this point.</p> <p>vi) There is no code of compliance for the new serviced apartment area.</p>	<p>fitted and operational.</p> <p>iv) Ensure the elevator is fitted and operational.</p> <p>vi) Ensure the new serviced apartment area has a current code of compliance.</p> <p>Prior to occupancy days</p>
<p>Criterion 1.4.4.1</p> <p>Adequate space is provided to allow the consumer and service provider to move safely around their personal space/bed area. Consumers who use mobility aids shall be able to safely maneuvers with the assistance of their aid within their personal space/bed area.</p>	PA Low	There are doors fitted leading from the apartment lounges into the bedrooms, however these overlap the entrance way in to the adjoining ensuite bathroom.	<p>Partial Provisional: Doors leading from apartment lounges to bedrooms overlap the bathroom doorways and impede wheelchair and resident transfer equipment</p>	<p>Ensure all apartment doorways allow unfettered resident access.</p> <p>Prior to occupancy days</p>

			access.	
<p>Criterion 1.4.7.1</p> <p>Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.</p>	PA Low	<p>There is a facility emergency evacuation plan and orientation programme, however these have not yet been applied to the reconfigured serviced apartment area.</p> <p>There are emergency/fire call panels in the facility, however those in the area of construction are not yet linked to the existing system.</p>	<p>Partial Provisional:</p> <p>i) Currently facility staff have not yet had fire and evacuation training, or an orientation for the new serviced apartment area.</p> <p>ii) Emergency/fire call panels in the new serviced apartment area are not yet operational.</p>	<p>i) Ensure all staff complete an orientation to, and fire/evacuation training for the new serviced apartment area.</p> <p>ii) Ensure all emergency/fire call panels are operational and linked to the existing facility system.</p> <p>Prior to occupancy days</p>
<p>Criterion 1.4.7.3</p> <p>Where required by legislation there is an approved evacuation plan.</p>	PA Low	<p>The building has an approved emergency evacuation scheme; however, this does not incorporate the new serviced apartments verified during the partial provisional audit.</p>	<p>Partial Provisional:</p> <p>There is no approved evacuation scheme for the new serviced apartments area.</p>	<p>Ensure there is an approved evacuation scheme that incorporates all areas of the building of the serviced apartments.</p>

				Prior to occupancy days
<p>Criterion 1.4.7.5</p> <p>An appropriate 'call system' is available to summon assistance when required.</p>	PA Low	The building has an existing nurse call system, however the call panels in the new serviced apartments are not yet linked to the existing system.	<p>Partial Provisional:</p> <p>The call panels in the serviced apartments are not operational.</p>	<p>Ensure the call panels in the serviced apartments are linked to the existing system and fully operational.</p> <p>Prior to occupancy days</p>

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 of this audit.

No data to display

End of the report.