

# Summerset Care Limited - Summerset in the River City

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## Introduction

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

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

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

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

The specifics of this audit included:

**Legal entity:** Summerset Care Limited

**Premises audited:** Summerset in the River City

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

**Dates of audit:** Start date: 21 April 2021 End date: 22 April 2021

**Proposed changes to current services (if any):**

**Total beds occupied across all premises included in the audit on the first day of the audit:** 36

# Executive summary of the audit

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## 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 in the River City provides care for up to 37 residents at hospital and rest home level care in the care centre, rest home level care across serviced apartments in a separate building. On the day of the audit, there were 36 residents including one rest home resident in the serviced apartments.

This unannounced surveillance audit was conducted against a subset of the 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 and staff.

Summerset in the River City has a site-specific business plan and quality plan. The plan includes health and safety and is linked to the village manager's performance indicators and also encouraging a dementia friendly service. There are quarterly reviews of the plan.

The village manager has been in the current role at Summerset for over five years and has attended leadership training through Summerset conferences. The village manager is supported by a care centre manager/RN who has been in the role for two years. The care centre manager is supported by a clinical nurse leader.

This audit has identified one area requiring improvement around documenting care interventions.

## 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.

Summerset in the River City provides care in a way that focuses on the individual resident. Families are regularly updated of residents' condition including any acute changes or incidents. Complaints processes are implemented and managed in line the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights. 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.

Standards applicable to this service fully attained.

Summerset in the River City has a well-established quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to a number of meetings including monthly quality improvement meetings. Annual surveys and monthly resident meetings provide residents and families with an opportunity for feedback about the service. Quality performance is reported to staff at meetings and includes discussion about incidents, infections and internal audit results. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care. There is a staffing policy in place.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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Registered nurses are responsible for care plan development with input from residents and family. Long-term care plans reviewed were completed within policy timeframes. Residents and family interviewed confirmed that the care plans are consistent with meeting residents' needs. Planned activities are appropriate to the resident's assessed needs and abilities and residents advised satisfaction with the activities programme. Medications are managed and administered in line with legislation and current regulations. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

## 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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Summerset in the River City has a current building warrant of fitness. Reactive and preventative maintenance is carried out. Hot water temperatures are monitored and recorded. Residents' rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. The service has implemented policies and procedures for civil defence and other emergencies and six-monthly fire drills are conducted.

## 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. The service is restraint free. Staff receive regular education and training on restraint minimisation.

## 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 is appropriate for the size and complexity of the service. The infection control coordinator (RN) is responsible for coordinating and providing education and training for staff. The infection control coordinator has attended external training. 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.

## 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	15	0	1	0	0	0
Criteria	0	40	0	1	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 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The organisational complaints policy states that the village manager has overall responsibility for ensuring all complaints (verbal or written) are fully documented and investigated. There is a complaint register that included relevant information regarding a complaint. There was one complaint received in 2020 and none year to date for 2021. The complaint documentation was completed within the required timeframes. Complaints and concerns are discussed at the relevant facility meeting. A complaints procedure is provided to residents within the information pack at entry. Feedback forms are available for residents/relatives at the main entrance.
Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment	FA	There is a policy to guide staff on the process around open disclosure. The facility manager and clinical manager confirmed family are kept informed. Relatives (two hospital and two rest home) and residents (two hospital and two rest home) stated they are notified promptly of any incidents/accidents. Residents/relatives have the opportunity to feedback on service delivery through annual surveys and open-door communication with management. Resident meetings encourage open discussion around the services provided (meeting minutes sighted). Two monthly newsletters to residents and family also ensure they are well informed. Accident/incident forms reviewed evidenced relatives are informed of any incidents/accidents. Relatives interviewed stated they are notified promptly of any changes to residents' health status.



conducive to effective communication.		If residents or family/whānau have difficulty with written or spoken English, the interpreter services are made available. Caregivers interviewed could describe how they communicated with one resident who did not speak English with the use of cue cards and body language to meet the resident needs.
<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>The service provides care for up to 37 residents at hospital and rest home level care in the care centre and rest home level across 12 serviced apartments in a separate building. On the day of the audit, there were 35 residents in the care centre with 22 at rest home level (including two respite residents and one funded through intermediate care funding) and 13 hospital level including one funded through continued medical interventions funding. There was one rest home resident in the serviced apartments. All 37 care centre beds are dual purpose.</p> <p>Summerset in the River City has a site-specific business plan and quality plan. The plan includes health and safety and is linked to the village manager's performance indicators and also encouraging a dementia friendly service. There are quarterly reviews of the plan.</p> <p>The village manager has been in the current role at Summerset for over five years and has attended leadership training through Summerset conferences. The village manager is supported by a care centre manager/RN who has been in the role for two years. The care centre manager is supported by a clinical nurse leader.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>Summerset in the River City is implementing the organisation's 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>There are a series of meetings including monthly quality meetings, monthly infection control meetings, caregiver meetings, and monthly RN meetings. Meeting minutes sighted evidenced staff discussion around accident/incident data, health and safety, infection control, audit outcomes, concerns and survey feedback. The service collates accident/incident and infection control data. Monthly comparisons include detailed trend analysis and graphs. The staff interviewed were aware of quality data results, trends and corrective actions.</p> <p>There is a robust internal audit programme that covers all aspects of the service and aligns with the requirements of the Health and Disability Services (Safety) Act 2001. A summary of internal audit outcomes is provided to the quality meetings for discussion. Corrective actions are developed, implemented and signed off.</p> <p>There is an implemented health and safety and risk management system in place including policies to guide practice. The manager is responsible for health and safety education, internal audits and non-clinical accident/incident investigation. There is a current hazard register. Staff confirmed they are kept informed on health</p>

		<p>and safety matters at meetings.</p> <p>Annual resident/family surveys are completed with the most recent September 2020. The survey documented 100% overall satisfaction.</p> <p>Falls management strategies include assessments after falls and individualised strategies. The service has detailed emergency plans covering all types of emergency situations and staff receive ongoing training around this.</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>Incident and accident data have been collected and analysed. Ten resident related falls incident reports for were reviewed. All reports and corresponding resident files reviewed evidenced that appropriate clinical care has been provided following an incident and the relative had been notified. Neurological observations had been completed for un-witnessed falls and any known head injury. 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. Discussions with the village manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been no notifications to report. There has been one outbreak, which occurred in December 2020 and regional public health were informed.</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. The register of RNs practising certificates and allied health professionals is current. Five staff files were reviewed (two RNs and three caregivers). All files contained relevant employment documentation including current performance appraisals and completed orientations. Current practising certificates were sighted for the registered nurses. All required staff have been employed and appropriate employment practices followed. The service has an orientation programme in place that provides new staff with relevant information for safe work practice in the provision of rest home and hospital level care. Staff interviewed believed new staff are adequately orientated to the service on employment.</p> <p>There is a comprehensive annual education planner in place that covers compulsory education requirements. The planner and individual attendance records are updated after each session. Five of the eight RNs have completed interRAI training. Clinical staff complete competencies relevant to their role. The RNs and clinical manager have access to external training.</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>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. There is a Clinical Nurse Leader on Monday to Thursday and a senior RN covers the days off. There is an additional RN on morning shifts across seven days.</p> <p>There are five caregivers on morning shifts (three full shift and two short shifts), four on the afternoon (two full shift and two short shift) and two caregivers on the night shift in the care centre. One caregiver with a first aid certificate is allocated to attend emergency calls in the village.</p> <p>The serviced apartments are in a separate building and there is a caregiver on duty 24 hours. During the week, care centre manager or the CNL visit the rest home level of care resident and documents these visits in VCare. The RN on duty remains on call for any incidents, accidents or concerns relating to these residents.</p> <p>Caregivers interviewed confirmed that staff are replaced. 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>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>The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management. The service uses an electronic charting and administration system and individualised robotic medication rolls which are checked in on delivery. All medicines are stored securely when not in use. A verification check is completed by the RN against the resident's medicine order when new medicines are supplied from the pharmacy. Medication orders include indications for use of 'as needed' medicines. Short-life medications (ie, eye drops and ointments) are dated once opened.</p> <p>All long-term residents and the respite residents have their medication recording on an electronic system. Administration sheets sampled were not all appropriately signed for the respite resident. Seven electronic medication charts (long term residents) reviewed identified the medication chart was signed each time a medicine was administered by staff. A registered nurse was observed administering medications and followed correct procedures. The GP had seen the residents three-monthly and medication charts had been reviewed. There were no residents who self-administer medicines.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's</p>	FA	<p>All meals are cooked on site. There is an six-week rotating menu approved by the dietitian. The verified food control plan expires January 2022. There are alternative meal options available and resident likes/dislikes and preferences are known and accommodated. Special diets include diabetic and pureed meals as assessed for residents by the RN. The cook receives a dietary profile for each resident. Supplements are provided to residents with identified weight loss issues. Weights are monitored monthly or more frequently if required and as directed by a dietitian. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food</p>

individual food, fluids and nutritional needs are met where this service is a component of service delivery.		<p>services generally. Residents and family members interviewed indicated satisfaction with the food service.</p> <p>The kitchen is well equipped. The fridge, freezer and dishwasher have daily temperatures recorded. End-cooked food temperatures are recorded daily. Cleaning schedules are maintained. Chemicals are stored safely within the kitchen which is locked after hours. Staff were observed wearing correct personal protective clothing. Staff working in the kitchen have food handling certificates and chemical safety training.</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>	PA Low	<p>A record of each resident's progress is documented. Changes are followed up by a registered nurse. When a resident's condition alters, the registered nurse initiates a review and if required, a GP consultation or referral to the appropriate health professional is actioned. Not all monitoring needs prescribed by the GP were documented.</p> <p>The clinical staff interviewed advised that they have all the equipment referred to in care plans necessary to provide care. Dressing supplies are available and treatment rooms are well stocked for use. Wound documentation was reviewed and included wound assessment, treatment plans and evaluations and progress notes for all wounds. Not all wound care interventions were according to timeframes. There were three facility acquired pressure injuries (two stage two and one stage one). Wound care nurse specialist advice is readily available, and photos are taken of all chronic wounds and a separate short-term care plan is generated for each wound.</p> <p>Continence products are available and specialist continence advice is available as needed. Short-term care plans with interventions and ongoing evaluations by the RN were evidenced. A physiotherapist referral is initiated if required and assessment of any equipment needed.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activities staff (a qualified diversional therapist and one in training) continue to provide an activities programme over seven days each week. The programme is planned monthly, and residents receive a personal copy of planned monthly activities. The activities plan for the month are displayed in large style colour format on noticeboards around the facility. A diversional therapy plan is developed for each individual resident based on assessed needs. Residents are encouraged to join in activities that are appropriate and meaningful and are encouraged to participate in community activities. The service has a van that is used for resident outings and a car that is used for resident transport. Residents were observed participating in activities on the days of audit. Resident meetings (monthly) provide a forum for feedback relating to activities. Residents who are unable to or choose not to participate are visited for one-on-one discussions and activities at least weekly. Residents and family members interviewed discussed enjoyment in the programme and the diversity offered to all residents.</p>
Standard 1.3.8: Evaluation	FA	<p>Care plans reviewed were updated as changes were noted in care requirements. Care plan evaluations are comprehensive, related to each aspect of the care plan and recorded the degree of achievement of goals and</p>

Consumers' service delivery plans are evaluated in a comprehensive and timely manner.		interventions. Short-term care plans are utilised for residents and any changes to the long-term care plan were dated and signed. Short-term care plans were in use. Care plans are evaluated within the required timeframes, but not all wound plans (link1.3.6.1).
Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	<p>The care centre and serviced apartments (two separate buildings) have a current warrant of fitness that expires on 2 February 2022. There is a full-time property manager who is available on call for facility matters. Planned and reactive maintenance systems are in place. Hot water temperatures have been tested and are on a monthly schedule with readings between 42-45 degrees Celsius. Preferred contractors are available 24/7.</p> <p>Corridors are wide in all areas to allow residents to pass each other safely. There is safe access to all communal areas and outdoor areas. There is outdoor seating and shade. There is a designated smoking area for residents who smoke.</p> <p>The caregivers and registered nurses (interviewed) stated they have all the equipment required to provide the care documented in the care plans. .</p> <p>There is a large reception area in the serviced apartments that care staff utilise as an office including secure storage for medications and treatment supplies.</p>
Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	<p>Surveillance is an integral part of the infection control programme. 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 service meetings. Meeting minutes are available to staff.</p> <p>Systems in place are appropriate to the size and complexity of the facility. The facility is benchmarked against other Somerset facilities of similar size and benchmarking results are fed back to the infection control officer and used to identify areas for improvement. Infection control audits are completed, and corrective actions are signed off (sighted).</p> <p>Covid-19 education has been provided for all staff, including hand hygiene and use of PPE.</p> <p>One outbreak during November 2020 was well managed. A post outbreak review was comprehensively documented, and areas of improvement followed up.</p>

<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There are policies around restraints and enablers. The service has no residents on restraint or with enablers. Alternative strategies and effective falls prevention strategies have ensured the facility remains restraint free since January 2018. Staff receive training around restraint minimisation that includes annual competency assessments. The restraint coordinator (CNL) oversees restraint minimisation for the service.</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)
Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Low	Care plans and wound care plans were documented comprehensively, including monitoring and evaluation timeframes. However, not all evaluations and monitoring were documented within timeframes.	(i).One resident with oxygen therapy did not have monitoring within timeframes requested by the GP.  (ii). Of the eight wounds documented, two had not always been evaluated within timeframes.	(i). Ensure all monitoring is documented according to timeframes.  (ii). Ensure that wounds are evaluated within timeframes and this is documented.  90 days

## Specific results for criterion where a continuous improvement has been recorded

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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.

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End of the report.