

Summerset Care Limited - Summerset In The Sun

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Summerset Care Limited
Premises audited:	Summerset in the Sun
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 29 November 2021 End date: 30 November 2021
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	75

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Summerset in the Sun is certified to provide hospital (geriatric and medical) and rest home level of care for up to 100 residents. There are 59 dual-purpose beds in the care centre on level one and 41 serviced apartments across two floors certified for rest home level of care. On the day of the audit, there were 75 residents in total including 26 rest home residents in the serviced apartments.

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

There are well-developed systems, processes, policies, and procedures that are structured to provide appropriate quality care for residents who live in the service. Implementation is supported through the quality and risk management programme. Quality initiatives are implemented which provide evidence of improved services for residents.

A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support, is in place.

Service provision is comprehensive and overall care plans are updated for changes in health status.

The village manager has been in the role at Summerset for five years. The care centre manager (who is also a registered nurse) has been in various roles with Summerset since 2015 and in this current role since 2018. The managers are supported by a clinical team lead and a Summerset regional manager.

This audit identified an improvement required around wound classifications.

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.
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The facility provides care in a way that focuses on the individual resident. There is a Māori health plan and cultural safety policy supporting practice. Cultural 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. Informed consent processes are implemented. Complaints and concerns are managed and documented. Residents and family interviewed verified ongoing involvement with their 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.
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Summerset in the Sun implements a 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. Data is collected from the electronic system including surveys, internal audits, complaints, and review of key performance indicators (KPIs). Several quality improvement projects focused on clinical improvements are ongoing since the last audit. These clinical improvement projects include falls reduction, skin tear and bruising reduction, dining experience, poly-pharmacy reduction, and continence improvements.

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, staff training and development. The service has an orientation programme that provides new staff with relevant information to ensure safe work practice. There is an in-service training programme covering relevant aspects of care and competencies are completed by staff annually. There is a staffing policy in place. The use of personal and health information of residents is accurate, sufficient, secure, accessible, and confidential.

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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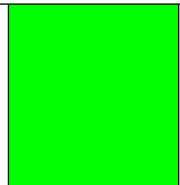
There is an admission/welcome pack available for potential residents and families. The registered nurses complete risk assessments, interRAI assessments, initial and long-term care plans, and evaluations within the required timeframes. Allied health professionals are involved in the care of the residents. The general practitioner reviews residents at least three-monthly.

The activities team provides a varied and interesting programme seven days a week. The activities meet the individual recreational needs and preferences of the residents. There are outings into the community and visiting entertainers.

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

All meals and baking are freshly prepared on site. The menu is reviewed by a dietitian. A current food control plan is in place. Resident's individual dietary needs were identified and accommodated. Food services staff have attended food safety and hygiene training. Residents commented positively on the meals provided.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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There were documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Chemicals were stored safely throughout the facility. The building has a current warrant of fitness. Resident apartments are spacious and personalised. Resident rooms in the care centre were spacious enough for the use of mobility and transferring equipment. All communal areas including the gardens and grounds were easily accessible and seating and shade is provided. There are procedures for civil defence and other emergencies. Adequate civil defence supplies were sighted. There is always one person on duty with a current first aid certificate. Housekeeping/laundry staff maintain a clean and tidy environment. Laundry and linen for rest home residents are laundered on site. There is plenty of natural light in all rooms and the environment is comfortable with adequate ventilation and heating.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.

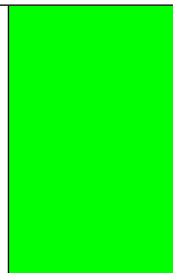


Standards applicable to this service fully attained.

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. Staff receive regular education and training on restraint minimisation, enabler use and managing behaviours that challenge. There were no residents using an enabler or restraint at the time of audit.

Infection prevention and control

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



Standards applicable to this service fully attained.

The infection control programme is appropriate for the size and complexity of the service. The infection control coordinator/RN is responsible for overseeing the infection control programme, collation of infection events, coordinating and providing education and training to staff. The infection control coordinator is supported by personnel at head office and an infection control committee. The infection control manual outlined the scope of the programme and included a comprehensive range of policies and guidelines including Covid outbreak management. 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.

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	1	0	0	0
Criteria	0	92	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
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	<p>FA</p>	<p>Details relating to the Code are included in the information pack provided to new residents and their relatives/whanau on admission. The care centre manager and village manager discuss aspects of the Code with residents and their whanau on admission.</p> <p>The Code of Health and Disability Services Consumers' Rights is also displayed at the entrance to the facility and is also available and displayed in accessible formats such as te reo Māori. There are pamphlets available on both floors of the facility. A Summerset specific booklet is also available which includes 'your rights as a Summerset resident' and 'our commitment to you'.</p> <p>There are a number of policies related to consumer rights that reference and link to the Code of Health and Disability Services Consumers' Rights. The organisation has (and promote) a philosophy of inclusiveness and this is reflective in the business plan goals.</p> <p>Interviews with staff included the village manager, care centre manager, clinical nurse lead, three caregivers, six registered nurse, one diversional therapist, one activity coordinator, one property manager, one cleaner and one chef. All 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 the Code in 2021. Observation during the audit confirmed this in practice. An internal audit around the code of rights completed January 2021 achieved 100% relating to required outcomes.</p>

<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. Written general and specific consents were evident in the resident files reviewed. Caregivers interviewed confirm consent is obtained when delivering cares. Resuscitation orders had been 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) interviewed confirmed discussion occurs around resuscitation with families/EPOA where the resident was deemed incompetent to make an informed decision.</p> <p>Discussion with relatives identify that the service actively involves them in decisions that affect their relative's lives. All admission agreements sighted were signed. Residents interviewed stated they felt fully informed to make decisions about their care.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Information about the Nationwide Health and Disability Advocacy is available to residents on the noticeboard and in their information pack. Other formats are available such as information in te reo Maori. Details relating to the Code and advocacy services are included in the information pack provided to new residents and their relatives/whanau on admission. The care centre manager and village manager discuss aspects of the Code with residents and their whanau on admission. Residents interviewed confirmed they are aware of their right to access independent advocacy services and advocacy pamphlets are available at reception. Discussions with relatives confirmed the service provided opportunities for the family/enduring power of attorney (EPOA) to be involved in decisions.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents and relatives interviewed confirmed open visiting with restrictions during Covid alert levels, however this is communicated to residents and relatives. Visitors were observed coming and going during the audit. Activities programmes included activities of daily living, and opportunities to attend events outside of the facility for example, shopping and attending cafés and restaurants. Interviews with staff, residents and relatives confirmed that 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 provision of care.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and</p>	FA	<p>The complaints procedure is provided to residents and relatives on entry to the service. The village manager maintains a record of all complaints, both verbal and written, by using a complaint register. Documentation including follow-up letters and resolutions, demonstrate that complaints are being managed in accordance with guidelines set by the Health and Disability Commissioner.</p> <p>There were six complaints logged in the complaint register in 2020 and seven in the 2021 register. All</p>

<p>upheld.</p>		<p>complaints documented a comprehensive investigation, follow-up, and replies to the complainant. Complaints demonstrated resolution and all complaints except one recent complaint were closed.</p> <p>Discussions with residents and relatives confirmed they were provided with information on complaints and complaints forms are available on each floor. Residents have a variety of avenues they can adopt to make a complaint or express a concern. Residents/relatives making a complaint can involve an independent support person in the process if they choose.</p> <p>The Code of Health and Disability Services Consumers' Rights is visible, and available in te reo Māori, and English.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>The service provides information in the welcome pack to residents that includes the Code, complaints, and advocacy services. Information is given to the potential resident and to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident.</p> <p>Residents interviewed (three hospital, eight rest home including four in serviced apartments) and four relatives (one rest home and three hospital) interviewed, reported that the residents' rights are being upheld by the service. The Code (in English and Māori) are displayed at the main entrance of the care centre. Information about the Nationwide Health and Disability Advocacy Service is available to residents on the noticeboard and in their information pack. Other formats are available such as information in te reo Maori. There are opportunities for residents and relatives to provide feedback and discuss issues including through the resident/family meetings and the through the annual residents'/relatives' survey. The 2021 survey included a 92% satisfaction around sufficient information provided and 100% around protecting the dignity of residents and treating them with respect.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>Staff interviewed were able to describe the procedures for maintaining confidentiality of resident records, resident's privacy, and dignity. The managers and staff encourage each resident to engage with their own spiritual support and there were examples of residents who chose to meet with church or spiritual groups.</p> <p>Resident files include 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 residents' room.</p> <p>It was observed that residents are treated with dignity and respect. Staff were observed to use person-centred and respectful language with residents. Residents and relatives interviewed were positive about the service in relation to their values and beliefs being considered and met. Privacy is ensured and independence is encouraged in accordance with the Privacy of Resident Information Policy.</p>

		<p>Orientation and ongoing education for staff covers the concepts of personal privacy and dignity.</p> <p>There is an abuse and neglect policy. Staff receive education and training on abuse and neglect (last completed April 2021). There were no reported incidents of abuse or neglect recorded in the past year. Staff were able to describe the process of escalating any concerns and managers described the process of managing these.</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 in the Sun currently have no residents that identify as Maori and no staff that identify as Maori,</p> <p>The service has a site-specific Maori Health plan. The document is based around implementing the principles of Te Whare Tapa Whā, which ensures the wellbeing of the Kaumātua and their whānau are enabled. The document links to key networks including the Māori Health unit, Nelson/Marlborough DHB. This document is displayed in the nurse's station. There is a Summerset wide Maori Health Plan that was last reviewed July 2021. At an executive level the organisation has recently appointed a Maori consultant (Deloitte) who will attend annually to report on Maori-related clinical indicators, health outcomes, significant complaints or concerns and actions for further development.</p> <p>The organisational Maori Health plan identifies that Summerset is committed to enabling the achievement of equitable health outcomes between Māori and non-Māori residents. This is achieved by applying the treaty principles and enabling residents and their whānau to direct their care in the way they choose.</p> <p>Interviews with care staff (three caregivers, seven registered nurses, one diversional therapist) identified the service and organisation are focused on delivering person-centred care which includes operating in ways that are culturally safe. The service has a training package that covers Maori health development and cultural safety that support the principles of Te Tiriti o Waitangi. This was completed by the majority of staff October 2021.</p> <p>Electronic resident care plans on their electronic patient care system include identifying values and beliefs.</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,</p>	FA	<p>An initial care planning meeting is carried out where the resident and/or whānau 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 is invited to attend. Discussion with relatives confirmed values and beliefs are considered. Residents interviewed confirmed that staff consider their culture and values.</p> <p>The service has a spirituality identity and cultural safety policy and procedure in place. Staff described how they implement a rights-based model of service provision through their focus on delivering a person-centred model of care.</p>

<p>spiritual values, and beliefs.</p>		<p>In developing the residents care plan, the resident receives support to include cultural identity in their care or support goals. Cultural assessments were evident on files reviewed. Electronic residents' files and care plans identified residents preferred names. Spiritual needs are identified, church services are held, and a chaplain is available.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Staff job descriptions include responsibilities and staff sign a copy at employment. House rules and a code of conduct are included in the employment contract and staff sign a professional boundaries policy on employment. The staff and clinical meetings occur monthly and include discussions on professional boundaries and concerns as they arise. Management provides guidelines and mentoring for specific situations.</p> <p>Interviews with the caregivers and registered nurses (RNs) confirmed an awareness of professional boundaries. Caregivers and RNs interviewed were knowledgeable around the scope of their role and responsibilities. The registered nurses supervise staff to ensure professional practice is maintained in the service.</p> <p>Summerset has a Diversity & inclusion policy). They have a zero-tolerance approach to racism/discrimination and instances of such would be managed as per the management of misconduct policy.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</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. There is a quality improvement programme that includes performance monitoring against clinical indicators and benchmarking against like services within the group is undertaken. There is a culture of ongoing staff development with an in-service programme implemented in 2020 and 2021.</p> <p>There is an embedded quality and risk management programme. Registered nurses are given a shared portfolio to manage, and this ensures that there is a focus on KPIs (e.g., falls prevention, infection control restraint, wound management, continence, medication management, or manual handling).</p> <p>There is good liaison and working relationship with the district health Board (DHB) personnel and external organisations such as Hospice. There are implemented competencies for caregivers and registered nurses specific to their roles.</p> <p>Residents interviewed spoke very positively about the care and support provided and stated the management team are very approachable.</p> <p>Staff interviewed had a sound understanding of principles of aged care and stated that they feel supported by</p>

		<p>the management team. Teamwork was observed during the audit.</p> <p>The management team described ongoing improvements since the last audit. They continue to work on quality improvement projects around falls, skin tears and bruising reduction. Improvements to statistics have been identified over the last two years. The service has introduced a new call bell system which operates in silence mode and staff are carrying pagers. Residents advised they are now sleeping better and feel less anxious as they don't hear call bells ringing. Training attendance has significantly improved due to the introduction of training days, covering topics for three-months in one day.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Monthly resident meetings identify feedback by residents and consequent follow-up by the service.</p> <p>Policies and procedures relating to accident/incidents, complaints, and open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. Electronic accident/incident forms have a section to indicate if next of kin have been informed (or not) of an accident/incident. Ten electronic accident/incident forms reviewed (November 2021), identified relatives were kept informed. Relatives interviewed stated that they are kept informed when their family member's health status changes. Regular newsletters for residents and relatives are provided, updating them on the month and upcoming events.</p> <p>The Code of Rights internal audit included communication and was last completed January 2021 identified 100% outcome. The resident satisfaction survey completed for 2021 resulted in 92% satisfaction around residents and family receiving sufficient information; and people being informed of changes resulted in 97% satisfaction.</p> <p>Interpreter services are used where indicated and contact details of interpreters is available.</p> <p>Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The residents and family are informed prior to entry, of the scope of services and any items that are not covered by the agreement.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Summerset in the Sun provides care for up to 100 residents at hospital (geriatric and medical) and rest home level of care. There are 59 dual-purpose beds in the care centre on level one and 41 serviced apartments across two floors certified for rest home level of care. On the day of the audit, there were 75 residents in total - 43 residents at rest home level including 26 rest home residents in the serviced apartments and 32 hospital level residents. There were three residents absent during audit as they were acute inpatients at the local DHB hospital. All residents are under the ARC contract.</p> <p>The Summerset Group Limited Board of Directors have overall financial and governance responsibility and</p>

		<p>there is an overarching strategic business plan in place for the company, with national goals. Summerset in the Sun has a site-specific business plan and goals that are developed in consultation with the village manager, care centre manager and regional manager. The business plan and goals are reviewed quarterly. The business plan includes key village priorities around financial performance, resident satisfaction, Health & Safety, and providing high quality care to residents. Each priority (goal) includes quarterly reporting and an action plan. There are weekly management meetings, and the village manager reports to the regional manager. The regional manager is readily accessible and visits the site monthly. The service received a dementia-friendly recognition award in 2020.</p> <p>Summerset has identified three values; (i) Strong enough to care, (ii) one team, (iii) strive to be the best. Their founding philosophy is “We were founded on a deep respect for people and a strong belief that we will always put our residents at the heart of everything we do”.</p> <p>Interviews with the Summerset Head of Clinical Services confirmed their clinical steering committee is the governance body. They are responsible for setting strategy, risk, monitoring & reporting, culture & capability, and engagement.</p> <p>The governance body is involved in the quality and risk management system through reports to the board around clinical risk and other areas of risk across the Group. They also support each site around emergency planning and service continuity planning. The board liaises with other committees to help align the governance of quality and safety issues with governance of organisational risk and occupational health and safety issues.</p> <p>The village manager has been in the role at Summerset for five years. The village manager has a master’s degree in business administration. The care centre manager (RN) has been in various roles with Summerset since 2015 and in this current role since 2018. The village manager and care centre manager attend Summerset national conferences. Both managers have completed in excess of eight hours education annually related to managing a rest home/hospital.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe</p>	<p>FA</p>	<p>The care centre manager provides support for the service along with the regional quality manager and other head office staff when the village manager is on leave. The clinical nurse leader provides clinical oversight along with support from head office when the care centre manager is on leave. The regional quality manager provides oversight and support at any time.</p>

services to consumers.		
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>Summerset in the Sun is implementing an organisational quality and risk management system. Interviews with managers and staff reflected their understanding of the quality and risk management systems and described quality projects and quality outcomes.</p> <p>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 schedules of training and audit requirements for the month/year. The village manager and CCM complete monthly reports confirming completion of requirements. Quality management systems are linked to internal audits, incident and accident reporting, health and safety reporting, infection control data and complaints management. Data is collected from the provider's electronic care system, including surveys, audits, and review of key performance indicators (KPIs). 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 included as part of benchmarking across the organisation. Data is analysed and corrective actions are required based on benchmarking outcomes. The regional quality manager is alerted automatically through the system of any high-level accident/incidents (resident, staff and environmental). Data is analysed and the results discussed at a variety of meetings including monthly quality meetings, monthly staff meetings, clinical (registered nurse) monthly meetings, health and safety and other portfolio meetings such as for infection control. Meetings reviewed identified corrective action plans are documented with evidence of resolution of issues in a timely manner.</p> <p>A number of quality improvement projects around clinical improvements are ongoing since the last audit. These clinical improvement projects include falls reduction, skin tear and bruising reduction, improved dining experience, poly pharmacy reduction and continence improvements.</p> <p>An annual residents/relatives survey has been completed in 2021 with this reporting a 98.8% satisfaction rate which is above the overall Summerset outcome of 97.5%. The results have been communicated to residents and staff with an action plan implemented around activities, more regular family meetings, a move-in survey and communication.</p> <p>There is a health and safety and risk management programme in place including policies to guide practice and minimise risk. The service has health and safety officers who attend the health and safety meeting. They also serve to take issues to the committee on behalf of staff and bring back information from management after discussion. Each month there is a focus on one of the golden rules of safety. All staff and contractors receive a health and safety induction. The hazard register has been updated annually.</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. A physiotherapist is contracted one day a week and completes assessments on residents and manual handling competencies with staff.
<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>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.</p> <p>Incident and accident data has been collected and analysed. Ten incident forms were reviewed on the electronic system. Appropriate assessments, recordings, short term care plans and other interventions were in place. All reports and corresponding resident files confirmed that family were notified of any incident.</p> <p>Discussions with the village manager and care centre manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been two unexpected deaths reported to MOH/DHB, one complaint to DHB which was resolved on 11/06/2021 and a suspected norovirus outbreak February 2021.</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 resources policies to support recruitment practices. A record of RN and allied health professionals practising certificates is maintained. Nine electronic staff files (one clinical nurse leader, two RN, one diversional therapist, one cook, one maintenance person and three caregivers) were reviewed and all had relevant documentation relating to employment. Performance appraisals had been completed annually for those staff who have been employed for over 12 months.</p> <p>All roles have a position/job description which also reflect expected positive behaviours and values. Descriptions of roles cover responsibilities and additional functions, such as holding a restraint or infection prevention portfolio. There are also key caregiver roles such as team lead and caregiver coach.</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 the roles of the caregiver coach. Caregivers are encouraged to start level two of Careerforce once they have completed their orientation booklet or six months after their starting date.</p> <p>The service embeds their person-centred principles as part of the orientation and induction processes.</p> <p>The service support access to mandatory and other relevant training. There is an annual education and training schedule being implemented that includes mandatory training across 2021. Advised that training attendance has significantly improved due to the introduction of training days, covering topics for three months in one day. There are specific training packages and resources and – online learning material.</p>

		<p>Training meets contractual requirements.</p> <p>Staff complete competencies relevant to their role such as (but not limited to) medication, hand hygiene, moving and handling, wound and restraint competencies. A competency register is maintained and monitored. There is access to DHB study days and on-line palliative care training. There are 12 RNs, and all are interRAI trained including the clinical manager. The service is linked to the professional development recognition programme (PDRP) at the DHB, and all RNs have completed their PDRP.</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 service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. There are clear guidelines for increase in staffing depending on acuity of residents. 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 clinical nurse leader works Monday to Thursday.</p> <p>In the care centre, there are two RNs on morning duty, afternoon shifts and night shift. In the weekend there are three RNs rostered on the morning, and afternoon shift.</p> <p>There are nine caregivers on morning shifts (seven do full shifts).</p> <p>On the afternoon shifts there are eight caregivers. Caregivers also carry out certain roles such as team leader, bells, lounge watch and caregiver coach. There are two caregivers overnight supporting the registered nurse.</p> <p>In the serviced apartments there are four caregivers on morning shift (three full shift and one finishing at 1 pm). There are three caregivers on the afternoon shift (two full shifts and one finishing at 10 pm). There is one caregiver on night shift.</p> <p>Interviews with staff, residents, and relatives confirmed that staffing levels are sufficient to meet the needs of residents.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and</p>	FA	<p>The resident files are electronically documented and are 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, ensuring security of information. Individual resident files demonstrated service integration. The service has consent processes in place for data collection. An overarching policy and related procedures govern their service provider's information management system. They have in place a Privacy of Resident Information Policy and resident records procedure.</p>

accessible when required.		
<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>The care centre manager (CCM) or clinical nurse lead (CNL) screen all potential enquiries to ensure the service can meet the required level of care and specific needs of the resident. The admissions- initial assessment policy is currently in place to guide staff around admission procedures and timeframes. The policy clearly states roles and responsibilities to ensure a smooth transition for residents. All residents have a needs assessment completed prior to entry that identifies the level of care required. There is an admission/welcome booklet that outlines the services provided at Summerset in the Sun. Residents and relatives interviewed stated that they received sufficient information on admission and discussion regarding the admission agreement content, occurred. The admission agreement reviewed aligns with a) - k) of the age-related residential care (ARRC) contract.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Planned exits, discharges or transfers are coordinated in collaboration with the resident and family to ensure continuity of care. There are documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The service utilises the 'yellow envelope' system for transfers to the DHB (as sighted in a resident file). Accompanying documents including advance directives, emergency contacts, medication charts and a transfer form.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>There are medicine management policies and procedures that align with recognised standards and guidelines for safe medicine management practice. The RNs and senior caregivers are responsible for the administration of medications and have completed medication competencies and annual medication education. The RNs have completed syringe driver training. All medications and robotic rolls were evidenced to be checked on delivery with discrepancies fed back to the supplying pharmacy. Standing orders are not used by the service. The RNs have completed syringe driver competency.</p> <p>Medications for the care centre and serviced apartments are stored safely in the main medication room. There are monthly checks for stock levels and expiry dates of 'as required' medicines and hospital stock. Eye drops had been dated on opening. There were two rest home residents self-administering medications with a current self-administration of medication competency. Medications were observed to be stored in locked boxes in the residents' room. The medication fridge and medication room air temperature are monitored daily, and temperatures recorded were within acceptable limits. There is in place an air conditioning unit in the medication room to ensure medications are stored within acceptable temperatures.</p> <p>Eighteen electronic resident medication charts (four rest home, four serviced apartments, and ten hospital) were reviewed. Medication charts had photograph identification and allergy status recorded. Staff recorded the effectiveness of 'as required' medications in the electronic system and in the progress notes. All</p>

		<p>medication charts reviewed by the audit team, identified that the GP had completed the three-monthly review of the medication chart.</p> <p>An organisational group has been reviewing medication errors and implementing a medicines optimisation programme. The service is currently implementing an improvement project around reducing the number of medications each resident takes simultaneously (polypharmacy).</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>Food services at Summerset in the Sun has been provided by an external contractor until September 2021. Summerset now provides their own food services for the facility. The kitchen manager/chef (interviewed) is supported by a team of five cooks, four kitchen hands and café staff, who have all completed food safety training. There is a 12-week set seasonal menu which has been reviewed by a dietitian. The main meal is served at lunchtime, with a light meal served for dinner. The dining rooms in the serviced apartments and the care centre are spacious and provide adequate space for residents to move around with mobility aids and to maintains dignity for residents requiring assistance with meals.</p> <p>The chef receives a copy of the nutritional profile completed on admission for each resident. Cultural preferences and special diets are discussed on admission. Registered nurses interviewed describe referral of complex residents to a speech and language therapist and dietitian as required. Dislikes and food allergies are accommodated. Pureed meals are moulded to enhance appearance. Lip plates and specialised utensils are available as required. Meals are plated and delivered in hot boxes to the serviced apartment dining room. Meals are delivered in hot boxes and served by food services staff from the bain-marie in the care centre satellite kitchen.</p> <p>The food control plan expires January 2022. All food is stored safely and dated. All temperatures for fridges, freezers, end cooked foods, inward chilled goods and cooling food is recorded on the electronic food safety system. There are daily opening and closing checks completed and checks include cleaning duties. Chemicals are stored safely within the kitchen. Feedback is received from residents directly from the dining room on the day, through resident meetings and satisfaction surveys. The resident satisfaction survey identified 79% satisfaction around quality of the food service, and special needs being met 92%.</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</p>	FA	<p>The reason for declining service entry to potential residents should this occur, is communicated to the potential resident or family/whānau and they are referred to the original referral agent for further information. The reason for declining entry would be if there were no beds available or the service was unable to meet the residents assessed level of care.</p>

family/whānau is managed by the organisation, where appropriate.		
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	The registered nurse completes an initial assessment and care plan on admission to the service which includes relevant risk assessment tools including (but not limited to); falls risk, pressure injury, skin, continence, and nutritional assessments. Risk assessments are completed six-monthly or earlier due to health changes. InterRAI assessments and long-term care plans were completed within the required timeframes. A suite of assessments is available on the electronic system. Other available information such as discharge summaries, medical and allied health notes, and consultation with resident/relative or significant others are included in the resident electronic file. Outcomes of the assessments are linked to the care plan.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Long-term care plans documented on the electronic system describe the holistic individual support and interventions required to meet the resident goals for daily activities, mobility, nutritional, cognitive, cultural, spiritual needs, and medical supports. Changes to supports and needs are updated on the care plans as they occur. The resident and family members sign the long-term care plan acknowledgement document as sighted in the resident files. Short term care plans are used for short-term problems and are regularly reviewed. Ongoing problems are transferred onto the long-term care plan. Care plans demonstrate service integration and include input from allied health practitioners. Residents and whānau interviewed confirmed they were involved in care planning and decision making.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Low	<p>When a resident's condition changes the RN initiates a review and if required, a GP or nurse specialist consultation. Short term care plans are developed to guide staff for any resident short-term health changes. These are reviewed regularly to monitor progress against resident needs and supports. There was documented evidence in the resident files of family notification of any changes to health, including infections, accidents/incidents, appointments, GP visits and medication changes. Residents interviewed stated their needs are being met.</p> <p>Adequate dressing supplies were sighted. A monthly wound register is maintained. Electronic wound assessments with ongoing wound evaluations and treatment plans were in place for 15 wounds, (chronic ulcers, cancerous lesions, incontinence associated dermatitis, and skin tears), however, not all wounds were classified. Photographs are taken regularly and evidence progression towards wound healing or deterioration. The registered nurses and clinical nurse lead describe accessing the district nursing service for wound advice, and GP consultation notes document wound reviews.</p> <p>Adequate continence supplies were sighted during the audit. The service has access to a continence</p>

		<p>specialist through the DHB as required.</p> <p>There are a number of monitoring forms and charts available for use including (but not limited to) pain monitoring, observations, blood sugar levels, weight, food and fluid intake, fluid balance, bowel monitoring, turning charts, restraint, neurological observations and behaviour charts.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>There is a team of three (two diversional therapist and one activities assistants) who coordinate and implement the activity programme for the care centre over seven days a week from 9am to 4pm. The aim of the team is to provide a non-pharmaceutical intervention that is important to the health and wellbeing of the residents. The programme covers physical, cognitive stimulation, reminiscence, sensory stimulation, pet therapy, and art and crafts. The diversional therapist and activities coordinator complete activity assessments which include cultural and spiritual preferences and beliefs. Care plans are developed in partnership with the resident, family/whanau and the registered nurse has input to the activity care plan. The activities team are involved in the six-monthly care plan reviews. Daily attendance records are maintained.</p> <p>There is an activity coordinator for the serviced apartments and village. The programme is planned a month in advance and residents receive a copy of the weekly programme and a notice of 'key dates' for the month. Daily activities are posted in the blackboard to remind residents of what's on for the day. Some activities and entertainment are integrated with the village. Rest home residents in serviced apartments can choose to attend the rest home or the serviced apartment activities. Activities include (but are not limited to); chair zumba dancing, walking, outings, gardening, baking, and happy hours in the care centre.</p> <p>The programme for the rest home residents is displayed and includes (but not limited to): news and views, pamper days, group games, entertainers, arts and crafts, quizzes and word games, short stories, bible stories. There are church services held monthly and communion is offered each week.</p> <p>There is a men's group and a lady's group for residents to join if they choose. A range of entertainers visit the facility (as covid 19 restrictions and vaccination status allow) including pet therapy, art therapy, and musical entertainers. There is a massage chair in the family room for residents to enjoy. The service uses an electronic touch device which is used to calm residents who are anxious (makes calming sounds). The team make daily contact with residents who choose to stay in their rooms and ensure their recreational needs are being met.</p> <p>There are scenic drives due to the current covid19 restrictions the residents do not get out of the van. The residents choose the destinations. One on one sessions are held with residents who choose not to participate in the larger group activities. One on one activities are tailored to each individual residents' needs. These include (but are not limited to) hand massages, reading, walks, wheelchair walks, conversations and whatever the resident chooses to do on the day.</p> <p>Festive events and birthdays and national days including Mother's Day, Father's Day, Melbourne Cup day</p>

		<p>and Christmas are celebrated. The facility celebrated Matariki with soup, and a focus of coming together, promoting whanaungatanga and sharing experiences, the residents crafted and decorated stars for the celebration. Maori language week and Waitangi Day are observed. Where possible kapa haka groups visit the service.</p> <p>There are resident meetings which are open to family/whanau to attend. Residents have the opportunity to feedback suggestions for activities and outings. The 2021 resident satisfaction survey included 91% - 96% satisfaction around various questions related to the activity programme. A corrective action, was implemented. The activities team report the residents also often provide verbal feedback following games and entertainment. Residents and families interviewed were happy with the activities offered.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>There is evidence of resident and family involvement in the evaluation of long-term care plans. The initial care plan is evaluated prior to the development of the first long-term care plan within 21 days. Written evaluations had been completed six-monthly, and where changes have occurred. InterRAI reviews are completed prior to the care plan evaluations. Families/whanau are offered a copy of the care plan for their information. The GP completes three monthly reviews. The diversional therapist evaluates the activity plan at the same time as the care plan evaluation. Documented evaluations reflect changes and progression towards meeting goals.</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>Referral to other health and disability services is evident in the resident files sampled. Mental health services, hospice, speech and language therapy and physiotherapy are some of the allied services accessed by resident referrals in consultation with GP. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Residents/EPOAs are informed and involved in the referral process.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are</p>	FA	<p>There are clear policies in place to guide staff in chemical safety and waste management. Management of waste and hazardous substances is covered during orientation and staff have attended chemical safety training. Chemicals sighted were clearly labelled with manufacturer's labels and stored securely throughout the facility. Material safety data (MSDS) and product sheets are available. Containers are available for disposal of used needles and syringes which meet the hazardous substances regulations requirements. A</p>

protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.		hazard register identifies hazardous substances and staff indicated a clear understanding of processes and protocols. Personal protective equipment (PPE) such as gloves, aprons, visors, and goggles is available to staff.
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building has a current building warrant of fitness that expires on 27 January 2022. All equipment and weigh scales has been tagged, tested, and calibrated on an annual basis. There is a full-time property manager who oversees the village and serviced apartments. He is supported by a team of maintenance and gardeners. The property manager is available on call for urgent facility matters. Essential contractors are available 24/7. Staff enter a 'job request' onto the electronic system to alert the maintenance team of reactive maintenance requests, which is signed off once completed. The planned maintenance schedule is set out by head office and includes internal, external, clinical, and environmental maintenance. Electrical equipment is tested and tagged annually or at least two-yearly. Hot water temperatures in resident areas are tested and recorded monthly and maintained below 45 degrees Celsius.</p> <p>There is lift access between the floors. The care centre is situated on the first floor. There are serviced apartments situated on the ground floor and first floor levels. There is plenty space for residents to mobilise using mobility aids throughout the facility and to the external areas. Residents were observed moving around freely around the care centre on the day of the audit. The external areas and gardens are well maintained. Designated external areas that have seating and shade. There is a covered outdoor courtyard in the care centre. Staff stated they have sufficient equipment to safely deliver care to meet resident needs.</p> <p>The service has two vehicles (a car and bus) to provide transport to residents and for staff usage. Both vehicles have current vehicle warrants of fitness and registration documents displayed. The 2021 resident satisfaction survey identified that 100% were satisfied with their room, 95% satisfied with the communal environment and 95% satisfied with the outdoor areas.</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</p>	FA	<p>Serviced apartment rooms have full ensuites of an appropriate design to meet the needs of the residents. All resident rooms in the care centre with the exception of four standard rooms have a full ensuite. There are communal toilet/showers closely located to the standard rooms. There are adequate numbers of communal toilets located near the communal areas. There is a shower room that is large enough to accommodate a shower trolley if required. The fixtures, fittings, floors, and wall surfaces are constructed from materials that can be easily cleaned. Communal toilet/shower facilities have a system that indicates if it is engaged or vacant.</p>

hygiene requirements or receiving assistance with personal hygiene requirements.		
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Resident rooms were spacious and are all certified for dual purpose use. There are two rooms which can have double occupancy, these had single occupancy on the days of the audit. All resident rooms provide adequate room to manoeuvre mobility aids and transferring equipment safely, such as a hoist and hospital lazy boy chairs. The doors are wide enough for ambulance trolley or evacuation chair access. Residents and families personalise their apartment or rooms as viewed on the day of audit. Serviced apartments are spacious and have a separate bedroom with a full ensuite. Each have a kitchenette area. All resident rooms and apartments were furnished with residents' personal adornments. Refurbishment of vacant rooms are completed as required.</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>Communal areas and outdoor areas are easily accessible for residents using mobility aids. Communal areas include a main lounge, two family rooms (with tea/coffee making facilities) and a dining room in care centre. There are spacious communal areas on the ground floor/serviced apartments including a dining room and café. There are seating alcoves within the facility, and a covered outdoor balcony for residents to enjoy. Outdoor areas provide seating and shade. External areas are well maintained by the gardening team. The foyer/ reception and café area are light, welcoming, and spacious, with café style seating in the café, and seating areas looking out to the manicured gardens.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>There are policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. All linen and personal clothing is laundered on site by a designated laundry person across seven days a week. There is a defined clean/dirty area with an entry and exit door. Laundry is delivered in bags down the chute from the care centre laundry collection room which is locked.</p> <p>There are two housekeepers in the care centre across seven days a week. Cleaning trolleys sighted were well-equipped and kept in designated locked cupboards when not in use. The housekeeper interviewed described taking chemicals into the room with them or keeping chemicals within line of sight. There is a closed chemical mixing system and adequate personal protective clothing available. Internal audits monitor the effectiveness of laundry and cleaning processes. The chemical provider monitors the use of chemicals. Chemical safety training has been completed. Housekeeping and laundry staff were knowledgeable around infection control practices in line with current best practice.</p>

<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>The Summerset in the Sun 2021 emergency management plan is in place to guide staff around all aspects of emergency management. Emergencies and first aid are included in the mandatory in-service programme. Summerset in the sun has an approved fire evacuation plan (18 February 2016), and fire drills occur six-monthly with the most recent on 26 June 2021. Smoke alarms, sprinkler system and exit signs are in place. The service has a generator and alternative cooking facilities (barbeque and gas hob) available in the event of a power failure. There are six 2,000 litre tanks in the ceiling 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 and solar lights that can be accessed from the garden areas. There is a first aid trained staff member on every shift.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>Visual inspection evidenced that the residents have adequate natural light in the bedrooms and communal rooms, safe ventilation, and an environment maintained at a safe and comfortable temperature. The facility is heated and cooled using air ducts. Resident rooms have heat pumps so residents can control heating to suit their preferences.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>The infection control programme is appropriate for the size and complexity of the service. The infection control coordinator/RN has been in the role for two years and has a job description that outlines the responsibility of the role. The infection control programme is linked into the quality management system and it is reviewed monthly via zoom meetings held with the national infection control team. The infection control coordinator is supported by an infection control committee who meet monthly. The infection control programme has been reviewed annually at an organisational level.</p> <p>Visitors are asked not to visit if they are unwell. Covid screening and health declarations remain in place. The service is currently operating under level 2 Covid restrictions. Influenza and Covid vaccines are offered to staff and residents. All staff have been fully vaccinated. Hand sanitisers and masks are readily available throughout the facility. All visitors and contractors are required to wear masks while in the facility, this is in line with current guidelines.</p>

<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The infection control coordinator has completed infection prevention and control online learning through the DHB in July 2021 and is registered to attend the infection prevention and control conference for 2022 (due to cancellation this year). The infection control committee meet monthly and are representative of the clinical, activities, laundry, and cleaning areas. There is access to expertise within the organisation, DHB, public health, laboratory, and GPs. There have been regular conference calls with the DHB in regard to outbreak management and preparedness. Summerset has a Covid plan for alert levels that has been updated August 2021 with new restrictions. Resource information was available from the Ministry of Health and DHB. There is a centrally located storage cupboard with sufficient personal protective equipment which is accessible to the staff.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>There are a suite of policies and procedures documented and available to staff electronically which reflect current best practice. Policies, procedures, and the pandemic outbreak planning have been reviewed to reflect Covid19 guidelines and recommendations. The service has developed an organisational pandemic plan for all facilities throughout the country.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control coordinator is responsible for coordinating and providing education and training to staff. The orientation package includes specific training around hand washing competencies, standard precautions and use of personal protective equipment. Ongoing training occurs annually as part of the training calendar set at head office. There has been additional training provided around Covid outbreak management, pandemic planning, alert levels and correct use of personal protective equipment/donning and doffing. Staff had been kept informed through regular memorandums and daily handovers.</p> <p>Resident education occurs as part of providing daily cares. Care plans can include ways to assist staff in ensuring this occurs. Residents and families were kept informed on Covid alert levels and visitor restrictions</p>

		through email, phone, and regular newsletters. Updates and signs relating to Covid were displayed at reception.
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>The infection control policy includes surveillance procedures. Infection events that meet the standard definitions are collected monthly and analysed for trends. The infection control coordinator provides infection control data, trends, graphs and relevant information to the infection control committee, regional quality manager, clinical and facility meetings. The facility is benchmarked against other Somerset facilities of similar size and benchmarking results are fed back to the infection control coordinator. Infection control audits are completed, and corrective actions signed off. Surveillance results are used to identify infection control activities and education needs within the facility.</p> <p>There was one suspected outbreak in 2021. Appropriate precautions were implemented, notifications were made in a timely manner and appropriate documentation was maintained.</p>
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	<p>The service has restraint and enabler policy and procedures in place. The policy is focused on minimising restraint use. The policy states: 'We aim to deliver care that meets the needs of the resident and maximizes their safety, restraint is used as a last resort only in all our Care Centres. We understand that restraining a resident has a negative impact on their quality of life. We acknowledge that there may be occasions where a resident's ability to maintain their own safety is compromised and the use of restraint may be clinically indicated'.</p> <p>A registered nurse is designated as the restraint coordinator. A job description which defines the responsibilities of the role is in place.</p> <p>There is no use of restraint or enablers in the service. Enablers are voluntary and the least restrictive option. There is a specific enabler consent, assessment, and evaluation process.</p> <p>Restraint use is a key clinical indicator and benchmarked across the organisation.</p> <p>Restraint minimisation, enabler training and training around management of challenging behaviour is provided annually. Audits of the use of any restraints or enablers occurs six-monthly.</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 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Low	Electronic wound assessments, plans and evaluations were completed for all the 15 wounds, however, not all the wounds were classified. The service uploads photographs regularly to evidence progression or deterioration of the wounds.	Eight of 15 wound charts reviewed did not indicate the type of wound.	<p>Ensure all wound classifications are documented on the wound charts.</p> <p>90 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.