

# Summerset Care Limited - Summerset at the Course

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## 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:

<b>Legal entity:</b>	Summerset Care Limited
<b>Premises audited:</b>	Summerset at the Course
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 15 February 2022      End date: 16 February 2022
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	48

# Executive summary of the audit

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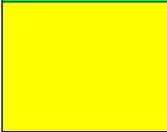
## Introduction

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

## General overview of the audit

Summerset at the Course provides rest home and hospital (geriatric and medical) level care for up to 40 residents in the care centre and up to 20 residents across the serviced apartments. On the day of the audit there were 48 residents.

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

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

No areas for improvement were identified as a result of this full certification audit.

## 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 service functions in a way that complies with the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and related services are readily available to residents and families. Policies are available that support residents' rights. Cultural assessment is undertaken on admission and during the review process. Residents and family interviewed verified ongoing involvement with the community. Care plans accommodate the choices of residents and/or their family. Complaints processes are being addressed in line with HDC requirements.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Summerset at the Course has an established quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to the monthly quality improvement meetings. Annual surveys and regular resident meetings provide residents and families with opportunities for feedback about the service. Quality performance is reported to staff at meetings and includes discussions relating to incidents, infections, and internal audit results. There are human resources policies that cover recruitment, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care. There is a policy for determining staffing levels and skill mixes for safe service delivery. This defines staffing ratios to residents, and rosters are in place and are adjustable depending on resident numbers. There are sufficient numbers of staff currently employed to cover the roster across each area.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.



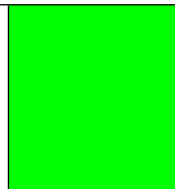
Standards applicable to this service fully attained.

The service has assessment processes and residents' needs are assessed prior to entry. There is an information pack available for residents and families/whānau at entry. Assessments, resident care plans, and evaluations were completed by the clinical nurse leader and registered nurses within the required timeframes. Risk assessment tools and monitoring forms were available and implemented. Resident care plans were individualised and included allied health professional involvement in resident care. A diversional therapist and team of volunteers implement an integrated activity programme.

The activities meet the individual recreational needs and preferences of the resident groups. There are outings into the community and visiting guests/entertainers. Some activities are currently curtailed/modified to meet covid restrictions. There are medicine management policies in place that meet legislative requirements. Staff responsible for the administration of medications complete annual medication competencies and education. The general practitioner reviews the medication charts three monthly. The food service, at time of audit, was contracted to an external company. Residents' individual dietary needs were identified and accommodated. Staff have attended food safety and hygiene training.

## 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.

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 rooms and bathroom facilities are spacious. All communal areas within the facility are easily accessible. The outdoor areas are safe and easily accessible and provide seating and shade. The service has implemented policies and procedures for civil defence and other emergencies and six-monthly fire drills are conducted. There is one person on duty at all times with a current first aid certificate. Housekeeping/laundry staff maintain a clean and tidy environment. There is plenty of natural light in all rooms and the environment is comfortable with adequate ventilation and heating.

## Restraint minimisation and safe practice

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

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection control programme is appropriate for the size and complexity of the service. The infection control officer (clinical nurse lead) is responsible for coordinating and providing education and training for staff. The infection control officer has completed training. The infection control manual outlined the scope of the programme and included a comprehensive range of policies and guidelines. The infection control officer 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	50	0	0	0	0	0
Criteria	0	101	0	0	0	0	0

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Discussions with three managers (care centre manager, village manager, clinical nurse lead) and fifteen staff (three caregivers, five registered nurses (RNs), one laundry, one recreational therapist, one national diversional therapist, one chef, one lead maintenance, two cleaners) confirmed their familiarity with the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and its application to their job role and responsibilities. Eight residents (three rest home residents, five hospital residents including one on a young person with a disability (YPD), and three relatives (all hospital level) interviewed confirmed the services being provided are in line with the Code. Observations during the audit also confirmed this in practice.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give</p>	FA	<p>Informed consent processes were discussed with residents and families on admission. Written general and specific consents (covid and influenza vaccine) were evident in the seven resident files (four hospital and three rest home level of care including one resident in the serviced apartments). Registered nurses and the clinical nurse leader 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. Discussion with family members identifies that the service actively involves them in decisions that affect their relative's lives. Seven long-term admission agreements sighted were</p>

informed consent.		signed.
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	Residents are provided with a copy of the Code on entry to the service. Residents interviewed confirmed they are aware of their right to access independent advocacy services and advocacy pamphlets are available at reception. Discussions with relatives confirmed the service provides opportunities for the family/EPOA to be involved in decisions. The resident files include information on residents' family/whānau and chosen social networks.
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	Visitors were observed coming and going during the audit. Interviews with staff, residents and relatives confirmed residents are supported and encouraged to remain involved in the community and external groups. Relatives and friends are encouraged to be involved with the service and care. The service promotes community visitors to the village and encourages resident involvement.
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are readily available. Information about complaints is provided on admission. Interviews with residents and family members confirmed their understanding of the complaints process.</p> <p>There is an electronic complaint register that includes verbal and written complaints and evidence to confirm that complaints are being managed in a timely manner including acknowledgement, investigation, timelines, corrective actions (when required) and resolutions. In 2021, six complaints lodged reflected evidence of follow-up actions taken and feedback provided in staff meetings including corrective actions (if any). No complaints have been received year to date (2022).</p> <p>One complaint was lodged with HDC on 22 February 2021. The Ministry requested follow up against aspects of this complaint that included communication, adverse event reporting, escalation of care, health assessment, short term care planning, and service delivery interventions. Corrective actions have been implemented. There were no identified issues in respect of this complaint. This complaint was closed by HDC on 29 September 2021.</p> <p>Complainants are provided with information on how to escalate their complaint if resolution is not to their satisfaction.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>The service provides information to residents that covers the Code, complaints, and advocacy. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Residents and relatives interviewed confirmed that they were well-informed about the Code. Residents' meetings are led by the activities staff. These meetings provide the opportunity for residents to raise concerns. An annual residents/relatives survey is completed.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Care staff interviewed were able to describe the procedures for maintaining confidentiality of resident records, resident's privacy, and dignity. Contact details of spiritual/religious advisors are available. Residents and relatives interviewed reported that residents are able to choose to engage in activities and access community resources.</p> <p>There are no shared rooms. One couple lives at the care centre, each with their own private room. Privacy locks and signage are installed on all public toilets.</p> <p>There is an elder abuse and neglect policy with evidence of staff training on this topic.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>Summerset has a Māori health plan. There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. The Code is posted in English and te reo Māori in visible locations. At the time of the audit there were no residents that identified as Māori. Staff interviewed were able to describe how they can ensure they meet the cultural needs of residents.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>An initial care planning meeting is carried out where the resident and/or whānau as appropriate/able are invited to be involved. Individual beliefs and values are discussed and incorporated into the resident's care plan. Six-monthly multi-disciplinary team meetings occur to assess if resident's needs are being met. Family is invited to attend. Discussions with family confirm values and beliefs are considered. Residents interviewed confirm that staff consider their culture and values.</p>
<p>Standard 1.1.7: Discrimination</p>	FA	<p>Staff job descriptions include responsibilities and staff sign a copy as part of the employment process. The monthly quality meetings include discussions on professional boundaries and concerns as they</p>

<p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>		<p>arise. Management provides guidelines and mentoring for specific situations. Interviews with managers and staff confirmed their awareness of professional boundaries.</p>
<p>Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Residents and relatives interviewed spoke positively about the care and support provided. Staff have a sound understanding of principles of aged care and state that they feel supported by the village manager, care centre manager and clinical nurse lead. All Somerset facilities have a master copy of policies which have been developed in line with current accepted best practice and are reviewed regularly. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff.</p> <p>There is a quality improvement programme that includes performance monitoring against clinical indicators and benchmarking against similar services within the Somerset group of aged care facilities. There is evidence of education and professional development being supported in addition to the implemented Somerset training plan. There are implemented competencies for caregivers and registered nurses including (but not limited to): insulin administration, medication, wound care, manual handling, oxygen administration, warfarin, restraint, and infection control/hand hygiene.</p>
<p>Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>An open disclosure policy describes ways that information is provided to residents and families. The admission pack gives a comprehensive range of information regarding the scope of service provided to the resident and their family on entry to the service and any items they are to pay for that are not covered by the agreement. Regular contact is maintained with family including if an incident or care/health issue arises. Family members interviewed stated they were well-informed. Ten incident/accident forms were reviewed and identified that the next of kin were contacted.</p> <p>Evidence was sighted of the implementation of the SBAR (situation-background-assessment-recommendation) tool as a framework for communication between members of the health care team in relation to a patient's condition.</p> <p>Resident's meetings are chaired by the activities staff. Issues or concerns are encouraged to be discussed. Minutes are maintained and show follow-up actions for resolution of matters raised.</p> <p>The service has policies and procedures available for access to DHB interpreter services. The information pack is available in large print and can be read to residents.</p> <p>Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so.</p>

<p><b>Standard 1.2.1: Governance</b></p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Summerset at the Course provides rest home and hospital level care for up to 60 residents. There are 40 dual purpose rest home/hospital rooms in the care centre and the service can also provide rest home level care for up to 20 residents across the 40 certified serviced apartments. On the day of the audit there were 48 residents: 12 rest home and 26 hospital residents in the care centre and 10 rest home level residents in the serviced apartments. Two residents (hospital) were on a younger person with a disability (YPD) contract and one resident (hospital) was receiving additional funding by the DHB for additional care/staff hours. The remaining residents were under the age-related residential care agreement (ARRC).</p> <p>There is a retirement village attached as part of the Summerset at the Course complex with overall management of the site provided by an experienced village manager who has been employed at Summerset for ten months. Prior to this role, he was the village manager at another facility for five years. The care centre is managed by a care centre manager (RN) who has been in her role for 20 months. She has been working in a managerial role in aged care for over 10 years. She is assisted by a clinical nurse leader (CNL). The CNL was employed five months ago and has worked in aged care as a unit coordinator for five years.</p> <p>The 2021 business plan was regularly reviewed, evidenced in the quality meeting minutes. The 2022 business plan and listed goals have been approved by head office.</p> <p>The village manager and care centre manager have maintained greater than eight hours of professional development activities related to managing an aged care facility.</p>
<p><b>Standard 1.2.2: Service Management</b></p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>The care centre manager fulfils the village manager's role during a temporary absence with support from the office staff, and clinical nurse lead.</p> <p>The care centre manager will be leaving her role later this month and will be temporarily replaced by a clinical manager/RN who also is responsible for a small (Summerset) rest home in the area. She has over five years of experience as a clinical manager and will assist with cover until a suitable care centre manager replacement is employed. She plans to be onsite a minimum of three days a week.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p>	<p>FA</p>	<p>An annual quality and risk management plan is in place. Policies and procedures reflect evidence of regular reviews as per the document control schedule. New and/or revised policies are made available for staff to read and sign that they have read and understand the changes. Summerset village</p>

<p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>managers and care centre managers are held accountable for their implementation.</p> <p>The monthly collating of quality and risk data includes (but is not limited to) residents' falls, bruising, skin tears and infection rates. Data is collated and benchmarked against other Summerset facilities to identify trends. A resident satisfaction survey is conducted each year. Results for 2021 generally reflect resident satisfaction with the services received. Corrective actions were implemented to address lower scores in relation to activities and communication.</p> <p>An annual internal audit schedule was sighted for the service. Corrective actions are developed where opportunities for improvements are identified and are signed off when completed. Staff are kept informed of audit findings either by attending meetings or reading the meeting minutes, which are emailed to them. Meeting minutes are also posted in the staff room. A range of examples of corrective actions implemented were discussed and included (but were not limited to) corrective actions in relation to an HDC complaint received that is now signed off, root cause analyses for all category one adverse events, restructure of the staff roster and implemented processes for pharmacy for the monitoring of medications that are brought to the facility.</p> <p>Falls prevention strategies are in place that include the identification of interventions on a case-by-case basis to minimise future falls. Strategies include (but are not limited to) sensor mats, perimeter mattresses, intentional rounding, and meetings with family to identify possible triggers). A physiotherapist is available one day a week (two hours) to assist in the development of falls reduction strategies for at-risk residents.</p> <p>A health and safety committee is in place. The committee meets monthly. Hazard identification forms and a hazard register are in place. Health and safety and fire training commence during staff orientation. This includes manual handling training, infection control training, Covid-19 prevention and outbreak planning and displaying monthly health and safety 'golden rules'. The village risk register is reviewed and updated monthly. A health and safety internal audit was last completed in November 2021. Staff receive health and safety training at orientation. This continues as a regular in-service topic. Contractors are also orientated to health and safety during their induction. This is repeated every year.</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</p>	<p>FA</p>	<p>The service collects a comprehensive set of data relating to adverse, unplanned, and untoward events. This includes the collection of incident and accident (events) information. The reporting system is integrated into the quality and risk management programme. Ten incident reports held electronically were sampled (six unwitnessed falls, two witnessed falls, one challenging behaviour, one soft tissue injuries (skin tear). All adverse events reviewed evidenced clinical follow up by a registered nurse with sign off by the CNL or care centre manager following review and investigation. Actions are implemented to prevent reoccurrence.</p>

<p>their family/whānau of choice in an open manner.</p>		<p>Evidence was sighted to confirm the escalation of care following a high-risk adverse event. Neurological observations are completed as per protocol for any unwitnessed fall and/or suspected injury to the head. If risks are identified these are processed as hazards.</p> <p>Discussions with the village manager and care centre manager have confirmed their awareness of statutory requirements in relation to essential notification. Section 31 notifications were completed in 2021 for grade three or unstageable pressure injuries. Public health authorities were notified following a respiratory outbreak in 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>	<p>FA</p>	<p>There are human resource policies and procedures, which includes the requirements of skill mix, staffing ratios, and rostering. Summerset has organisational documented job descriptions for all positions, which detail each position's responsibilities, accountabilities, and authorities. The service has implemented the policy addressing competencies and requirements for validating professional competencies. Copies of current practising certificates were sighted for registered nursing staff and external health professionals (e.g. GP, physiotherapist, pharmacists).</p> <p>An orientation programme is in place. Orientation training is offered online, with instructions for new staff to complete aspects of their orientation prior to beginning work onsite. The orientation programme also includes specific training and competencies (e.g. equipment, manual handling, safe chemical handling, medication, emergency, and fire training). The annual training plan includes a list of topics that must be completed at least two yearly, and this is reported on.</p> <p>Eight staff files were reviewed (four caregivers, two staff RNs, one CNL, one cook). Evidence of signed employment contracts, job descriptions, completed orientation and competencies that are specific to their job duties, and staff attendance at educational in-services were sighted. Performance appraisals for staff are conducted beginning twelve weeks following their orientation and annually thereafter. Reference checking is completed by an external agency. The care centre manager stated that she will not employ staff before ensuring reference checking has been completed.</p> <p>The service has a training policy and schedule for in-service education. The in-service schedule is implemented, and attendance is recorded. Inservice education is supported by competency assessments (e.g. hand hygiene, moving and handling, wound care, restraint, syringe driver, medication administration, oxygen administration, emergency management, health, and safety). The cook is a qualified chef. Chemical safety training is initiated at orientation and continues annually for applicable staff.</p> <p>Thirty-two caregivers are employed. Four have achieved a level 2 Careerforce qualification, seven hold a level 3 qualification and five have achieved a level 4 Careerforce qualification in health and wellbeing.</p> <p>Five RNs and two ENs are employed in addition to the care centre manager and CNL. Four RNs are</p>

		interRAI trained. The registered nurses have access to external training sessions.
<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>Human resource policies include documented rationale for determining staffing levels and skill mixes for safe service delivery (Safe staffing policy). This defines staffing ratios to residents, and rosters have been developed and are adjustable depending on resident numbers. There is also a document 'guidelines for management of fluctuating occupancy'. There is 24-hour RN cover.</p> <p>The care centre manager works Monday – Friday and high-risk clinical nurse lead works Sunday – Thursday. The care centre manager and CNL share on call responsibilities, alternating weeks.</p> <p>Care centre (12 rest home, 26 hospital): In addition to the clinical nurse lead, either two RNs or an RN and EN are rostered across the morning and afternoon shifts and one RN is rostered for the night shift. Caregiver staffing: am shift: three long (eight hour) and five short shifts; pm shift: three long shift and three short shifts; night shift: three long shifts.</p> <p>Serviced apartments (ten rest home level residents): a caregiver is staffed 24/7 with one long shift caregiver on each shift.</p> <p>Interviews with staff and residents confirmed that staff are very busy and that the residents' needs are being met.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident files were appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access. Care plans and progress notes are documented electronically. Resident files demonstrate service integration.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>All residents have a needs assessment completed prior to entry that identifies the level of care required. The care centre manager screens all potential enquiries to ensure the service can meet the required level of care and specific needs of the resident. Residents and relatives interviewed stated that they received sufficient information on admission and discussion was held regarding the admission agreement. The admission agreement reviewed aligns with the ARC contract. Seven admission agreements were sighted for long-term residents including one resident on a Younger Person Disabled Contract (over 65 years) and a resident receiving additional District Health Board funding for a high level of care.</p>

<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>There is an exit discharge and transfer policy that describes guidelines for death, discharge, transfer, documentation, and follow-up. All relevant information is documented and communicated to the receiving health provider or service – there is a specific transfer form. Follow-up occurs to check that the resident is settled or, in the case of death, communication with the family is made.</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 in accordance with the Medicines Care Guide for Residential Aged Care 2011. The RNs, enrolled nurses and senior caregivers are responsible for the administration of medications. Staff complete competencies for the checking and witnessing of medications as required. Medication education has been completed annually. All medications (in robotic rolls) were evidenced to be checked on delivery with any discrepancies fed back to the supplying pharmacy.</p> <p>There were no self-medicating residents. All medications were stored correctly. The two medication fridges and medication room are monitored with temperatures remaining in the desired ranges. Fourteen resident medication charts on the electronic medication system and corresponding medication administration sheets were reviewed. The medication charts had photograph identification and allergy status recorded. Staff recorded the time and date of 'as required' medications, and an indication for use was documented by the prescriber. The effectiveness of PRN medication was recorded on the Medimap system for all resident charts audited. All medication charts had been reviewed by the GP three monthly.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The service has a contracted company for the provision of all meals on-site (this will be changing shortly with the service coming inhouse – including a number of the staff). The kitchen and main dining room are adjacent, and meals are dished in the kitchen and taken directly to the residents. For other areas the meals are dished in the kitchen and transported in scan boxes. There is a twelve-week rotating menu approved by the organisational dietitian. The menu also has a vegetarian option. Resident likes/dislikes and preferences are known and accommodated, with alternative meal options. Textured modified meals, fortified foods, protein drinks and diabetic desserts are provided. The cook receives a dietary profile for each resident. The qualified chef (interviewed) is notified of any changes to residents' dietary requirements and resident preferences.</p> <p>The fridge, freezer, end-cooked food temperatures and serving temperatures are taken and recorded.</p>

		All foods are stored correctly, and date labelled. Cleaning schedules are maintained. Chemicals are stored safely within the kitchen. Staff were observed wearing correct personal protective clothing. The chemical provider completes a functional test on the dishwasher monthly. Staff working in the kitchen have food handling certificates. The food control plan expires January 2023.
Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	The reason for declining 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 the service was unable to provide the level of care required or if there were no beds available.
Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	The initial assessment including the risk assessment tools (as applicable) are developed with information received on admission including discussion with the resident and relatives. Clinical risk assessments are completed on admission and reviewed six-monthly as part of the interRAI assessment. Outcomes of risk assessment tools and interRAI assessment are used to identify the needs, supports and interventions required to meet resident goals. The interRAI assessment tool has been utilised six-monthly for all long-term residents including the resident under YPD funding. The stop and watch tool was now in place and evidence of it being used was in the file of the YPD resident.
Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Resident centred care plans describe the individual support and interventions required to meet the resident goals. The care plans reflect the outcomes of risk assessment tools and the interRAI assessment. Care plans demonstrate service integration and include input from allied health practitioners. Short-term care plans were in use for changes in health status. In the resident files reviewed there was evidence of short-term care plan use for anyone on antibiotics, an ingrown toenail, a wound, a haematoma, and urinary tract infections. These are evaluated regularly and either resolved or if an ongoing problem, added to the long-term care plan. There is documented evidence of resident/family involvement in the care planning process. Residents/relatives interviewed confirmed they participate in the care planning process.
Standard 1.3.6: Service Delivery/Interventions	FA	When a resident's condition changes, the RN initiates a review and if required a GP or nurse specialist consultation- evidence of this was available. Relatives interviewed state their relative's needs are met

<p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>and they are kept informed of any health changes. There was documented evidence in the resident files of family notification of any changes to health including infections, accidents/incidents, and medication changes. Residents interviewed state their needs are being met.</p> <p>Adequate dressing supplies were sighted. Initial wound assessments with ongoing wound evaluations and treatment plans were in place for eight residents with wounds. There were no pressure injuries.</p> <p>There was one chronic wound. The DHB wound nurse specialist is sent weekly updates and advice and support is received. One registered nurse onsite is the 'wound champion' and attends additional training on wounds. Pressure injury resources are readily available.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed.</p> <p>Monitoring charts sighted included (but not limited to); blood sugar levels, temperature, pulse and respirations, weight, photographs for wounds, food, and fluid, falls calendar.</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>The service employs a recreational therapist (RT) for 35 hours per week. She has been in the position for six months. Recruitment for a second recreational therapist for 15 to 20 hours week is currently being undertaken. The RT, who has had previous recreational therapist experience, has a first aid certificate and is undertaking diversional therapy training and Automobile Association training in order to drive the van. The RT undertakes an assessment of the resident identifying their previous, current, and potential interests and a plan is documented. Evidence showed the plans were individualised. Attendance records were maintained, and plans were evaluated six-monthly. The RT is involved in the multidisciplinary review, which includes the review of the activity plan.</p> <p>The head office diversional therapist (interviewed) forwards a framework for the monthly activities plan. An information booklet on activities has been written to inform residents/family on admission what is available. The RT has also commenced a regular newsletter for residents/family. There is a team of volunteers including entertainers and pet owners who out of covid restrictions help with various activities with residents. At present options of videos and U-tube music is offered. Residents get a copy of the programme and the monthly and weekly programme is displayed on a large board. The programme includes set activities, with the flexibility to add other activities of interest or suggestions made by residents. Activities meet the recreational needs of the residents, ensuring all residents have the opportunity to attend group activities such as newspaper reading, sing-alongs, word games/quizzes, crafts and "step out" walking group. The activities that involve going into the community and/or the community coming to the facility are currently curtailed.</p> <p>The service has a van for outings. Rest home residents in serviced apartments are invited to attend the</p>

		care centre programme. The YPD person (who is over 65) was interviewed and when not under covid restrictions finds the activities he goes to in the community very enjoyable. Resident meetings and annual surveys provide an opportunity for residents to feedback on the programme.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	There is evidence of resident and family involvement in the review of resident centred care plans. All initial care plans of the permanent residents were evaluated by the RNs within three weeks of admission. Written evaluations for long-term residents were completed six monthly or earlier for resident health changes. On review of care plans it is determined whether goals have been met and interventions altered accordingly. On interview residents stated their goals were being met  There is evidence of multidisciplinary (MDT) team involvement in the reviews, including input from the GP, care staff, RT and any allied health professionals involved in the resident's care. Families are invited to attend the MDT review and asked for input if they are unable to attend. Short-term care plans sighted have been evaluated by the RN. The GP completes three-monthly reviews.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence that specialist services were accessed including the DHB dietitian, wound specialist(ongoing), stoma therapist, continence specialist, speech therapist, the hospice, diabetic nurse specialist and the Older Persons Mental Health team. One file reviewed evidenced an example of where a resident's condition had changed, and the resident was awaiting reassessment for a higher level of care.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Safety data sheets were readily accessible for staff. Chemicals were stored safely throughout the facility. Personal protective clothing was available for staff and seen to be worn by staff when carrying out their duties on the day of audit. Relevant staff have completed chemical safety training.

<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 is two levels, with the care centre and serviced apartments on the ground floor and staff only areas upstairs. The building has a current building warrant of fitness that expires on 2 October 2022. A full-time property manager oversees a team of maintenance persons and groundsmen. Planned and reactive maintenance systems are in place and maintenance requests are generated through forms available to staff and collected daily by maintenance staff and closed off when completed. All electrical equipment has been tested and tagged. Clinical equipment has had functional checks/calibration annually.</p> <p>Hot water temperatures have been tested and recorded monthly with readings below 45 degrees Celsius. Essential contractors are available 24 hours. Corridors are wide in all areas, to allow residents to pass each other safely. There is safe access to all communal and outdoor areas. Outdoor areas provide seating and shade. The external areas are well maintained. Environmental improvements include refurbishment of rooms and communal areas. The caregivers (interviewed) state they have all the equipment required to safely provide the care documented in the care plans.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>All rooms are single and have either a full ensuite (24) or shared ensuite (16). Shared ensuites have a privacy lock and light that indicates the ensuite is engaged. Ten rest home level residents were receiving care in their individual serviced apartment. Fixtures, fittings, floors, and wall surfaces are constructed from materials that can be easily cleaned. There are adequate numbers of communal toilets located near the communal areas with privacy locks. Residents interviewed confirm the care staff respect their privacy when attending to their personal cares.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>The resident rooms are divided into three wings. There is adequate room to safely manoeuvre mobility aids and transferring equipment such as a hoist if required in the event of a fall. The doors are wide enough for ambulance trolley access. Residents and families are encouraged to personalise their units as viewed on the day of audit. The serviced apartments are adjacent to these wings. The serviced apartments are spacious with pleasant outlooks.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p>	FA	<p>Communal areas within the facility include a large main lounge and adjacent dining room. There is a conservatory sun lounge at the end of one wing. There is a family room with tea/coffee making facilities. Both wings of serviced apartments have a spacious dining area. There are several seating alcoves</p>

<p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>		<p>within the facility. The communal areas are easily accessible for residents.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. All linen and personal clothing is laundered on-site. There is a defined clean/dirty area with an entry and exit door. The laundry facility is well-equipped, and all machinery has been serviced regularly.</p> <p>Cleaning trolleys sighted were well-equipped and are kept in designated locked cupboards when not in use. Internal audits monitor the effectiveness of laundry and cleaning processes. On interview, a cleaner and a laundry assistant were knowledgeable of what was required of them and safe 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 site-specific emergency manual for Summerset at the Course covers emergency and disaster policies and procedures, including (but not limited to) fire and evacuation and dealing with emergencies and disasters. Emergencies, first aid and CPR are included in the mandatory in-services programme every two years and the annual training plan includes emergency training. Orientation includes emergency preparedness. There is a first aid trained staff member on every shift and on outings.</p> <p>The service has a generator available in the event of a power failure for emergency power supply. There are also extra blankets available. There is a civil defence locker which includes all necessary civil defence requirements. A 55,000-litre water supply is available in the event of an emergency.</p> <p>The call system involves a pager system whereby staff are alerted to a resident's call bell via the personal pagers held by each care staff member. Call bells are available in each bedroom and ensuite.</p> <p>The fire evacuation scheme has been approved by the New Zealand Fire Service. Fire drills take place six-monthly.</p> <p>Summerset at the Course is a gated facility. The gates are locked between dusk and dawn with fob access for the village residents. There is a main double-door entrance into the care centre that is secure at dusk with phone access. External security cameras are placed in strategic locations.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p>	<p>FA</p>	<p>All resident rooms have adequate natural light in the bedrooms and communal rooms, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. The facility is heated by underfloor heating with separate controls to keep rooms at required/desired temperatures. There is a</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>designated smoking area for staff away from resident areas. One resident vaped and was required to go outside to do so.</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. There is an infection control responsibility policy that includes responsibilities for the infection control coordinator. The infection control coordinator (CNL) has been in the role for six months and has a signed job description. The infection control programme is linked into the quality management system and reviewed annually at head office in consultation with infection control coordinator and overseen by the clinical improvement manager at head office whose focus is infection prevention and control. The quality improvement and staff meetings include a discussion of infection control matters. There is an infection control plan and goals for 2022 these have been reviewed to incorporate the management of covid. A monthly meeting is held of all Summerset infection control coordinators (ICC) and input/discussion on the programme is had.</p> <p>There are currently restrictions on visiting with a booking and vetting system in place. Visitors are asked not to visit if they are unwell. Influenza and covid vaccines are offered to residents and staff. Hand sanitisers are available throughout the facility.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The infection control coordinator has completed Ministry of Health LearnOnline Infection Prevention and Control training. There is an infection control committee that meets monthly. The committee are representatives of each service area. Committee members have also had education on infection prevention and control which is included in orientation and through zoom from head office. The facility has access to an infection control nurse specialist at the DHB, public health, Ministry of Health, laboratory, GPs, and expertise within the organisation. Summerset infection control coordinators have a monthly meeting online. There was a plentiful supply of equipment onsite.</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</p>	<p>FA</p>	<p>There are comprehensive infection control policies that are current and reflected the Infection Control Standard SNZ HB 8134:2008, legislation and good practice. These are across the Summerset organisation and are reviewed regularly by a clinical improvement manager at head office. The recent review included a focus on covid. The infection control policies link to other documentation and cross reference where appropriate.</p>

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.		
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control coordinator is responsible for coordinating and providing education and training to staff. The induction package includes specific training around hand washing competencies and standard precautions. Ongoing training occurs annually as part of the training calendar set at head office. The frequency of training has increased since the event of covid. There is an infection control noticeboard in the staffroom, displaying meeting minutes and quality data including graphs. Resident education occurs as part of providing daily cares. Care plans can include ways to assist staff in ensuring this occurs.
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	The infection control policy includes a surveillance policy, including a surveillance procedure, process for detection of infection, infections under surveillance, outbreaks and quality and risk management. Infection events are collected monthly and entered onto the VCare electronic system. The infection control coordinator provides infection control data, trends, and relevant information to the infection control committee. The quality committee meets quarterly and reviews the monthly infection events, trends, and analysis. Infection control data is accessed by the infection control coordinator for benchmarking using Power BI. Areas for improvement are identified, corrective actions developed and followed-up. Infection control audits are completed, and corrective actions are signed off. Surveillance results are used to identify infection control activities and education needs within the facility. There has been one RSV outbreak in August 2021. Relevant personnel were notified.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	There are policies around restraints and enablers. The service had one (hospital) resident assessed as requiring the use of restraint (lap belt) and one resident (hospital) requiring an enabler (bedrails). The care plans provide the basis of factual information in assessing the risks of safety and the need for restraint. On-going consultation with the resident and family/whānau are identified. Staff receive training around restraint minimisation that includes annual competency assessments.  The resident file for the resident using an enabler was reviewed. Enabler processes are the same as the Summerset restraint processes and include an assessment where risks are identified, voluntary consent is sought, and links to the care plan are documented that include risks associated with restraint

		or enabler use. All residents using an enabler, or a restraint are monitored a minimum of two-hourly.
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	A restraint approval process and a job description for the restraint coordinator are in place. The restraint coordinator role is delegated the clinical nurse leader who was very knowledgeable regarding this role. All staff are required to attend restraint minimisation training annually, which includes a competency assessment.
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	Only registered nursing staff can assess the need for restraint. Restraint assessments are based on information in the resident's care plan, discussions with the resident and family and observations by staff. The restraint assessment tool meets the requirements of the standard. The hospital level resident's file where restraint was being used was selected for review. This file included a restraint assessment and consent form that was signed by the resident's family. Restraint use is linked to the resident's care plan and is regularly reviewed.
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	A restraint register is in place. This register identifies residents that are using a restraint, and the type(s) of restraint used. The restraint assessment identified that restraint is being used only as a last resort. The restraint assessment and on-going evaluation of restraint use includes reviewing the frequency of monitoring residents while on restraint. Monitoring forms are completed when the restraint is put on and when it is taken off and indicate monitoring at the frequency described in each resident's care plan.
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	Restraint use is reviewed monthly during restraint meetings and three-monthly by the restraint coordinator. The review process includes discussing whether continued use of restraint is indicated.
<p>Standard 2.2.5: Restraint</p>	FA	The restraint programme, including reviewing policies and procedures and staff education, is evaluated

Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.		annually by the Somerset head office.
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## Specific results for criterion where corrective actions are required

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

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

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

No data to display
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## 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.