

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 Health and Disability Auditing New Zealand Limited, 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: 20 November 2017 End date: 21 November 2017
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:	62

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 provides rest home and hospital (geriatric and medical) level care for up to 59 residents in the care centre and rest home level care for up to 41 residents in the serviced apartments. On the day of the audit there were 50 residents in the care centre and 12 rest home residents in serviced apartments. The service is managed by a village manager (VM) and a care centre manager (CCM). The residents and relatives interviewed spoke positively about the care and support provided.

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

The village manager is appropriately qualified and experienced and is supported by a care centre manager (registered nurse) who oversees the care centre. There are quality systems and processes being implemented. An induction and in-service training programme is in place to provide staff with appropriate knowledge and skills to deliver care.

The service has been awarded continuous improvement ratings around good practice and restraint minimisation.

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.		All standards applicable to this service fully attained with some standards exceeded.
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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. An advocate from Age Concern attends resident's meetings. Care plans accommodate the choices of residents and/or their family. Complaints processes are being implemented and complaints and concerns are managed and documented. Residents and family interviewed verified ongoing involvement with 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. Annual surveys and monthly resident meetings provide residents and families with an opportunity for feedback about the service. Quality performance is reported to staff at meetings and includes discussion about incidents, infections and internal audit results. There are human resources policies including recruitment, selection, orientation and staff training and development. The service

has an orientation programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care. There is a staffing policy in place.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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The service has assessment processes and resident's needs are assessed prior to entry. There is an information pack available for residents and families/whānau at entry. Assessments, resident centred care plans, interventions and evaluations were completed by the registered nurses within the required timeframes. Risk assessment tools and monitoring forms were available and implemented. Resident centred care plans were individualised and reflected the resident's current needs and supports. Allied health professionals and the general practitioner are involved in the care of the residents.

A diversional therapist (in training) and recreational therapist coordinate and implement an integrated activity programme that meet the individual recreational needs and preferences.

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.

The food service is contracted to an external company. Resident's 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.
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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 bedrooms are spacious and personalised. There are bedrooms with ensuites and some closely located to communal toilet/showers. There was sufficient space to allow the movement of residents around the facility using mobility aids or lazy boy chairs. The hallways and communal areas were spacious and accessible. The outdoor areas were 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. Housekeeping/laundry staff maintain a clean and tidy environment. All laundry and linen are completed on-site. There is plenty of natural light in all rooms and the environment is comfortable with adequate ventilation and heating.

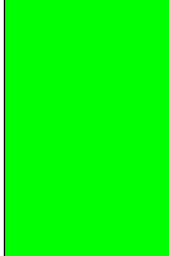
Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		All standards applicable to this service fully attained with some standards exceeded.
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Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort. Staff receive regular education and training on restraint

minimisation. There was one resident using an enabler and there were no residents requiring the use of a restraint at the time of audit.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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The infection control programme is appropriate for the size and complexity of the service. The infection control coordinator (registered nurse) is responsible for coordinating and providing education and training for staff. The infection control coordinator has attended external training. The infection control manual outlined the scope of the programme and included a comprehensive range of policies and guidelines. The infection control officer uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. These 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	2	44	0	0	0	0	0
Criteria	2	92	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 eleven staff (six care assistants, three registered nurses (RN), one recreational therapist and one diversional therapist in training) confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Five residents (three rest home and two hospital level of care) and seven relatives (five rest home and two hospital) were interviewed and confirmed the services being provided are in line with the Code. Observation during the audit 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 informed</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. Written general and specific consents were evident in the eight resident files reviewed (four rest home level of care including one resident in the serviced apartments and four hospital level of care including one respite resident). Six caregivers, and three registered nurses 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 a decision.</p> <p>Discussion with two relatives of a hospital level of care resident, and five of rest home care residents identify that the service actively involves them in decisions that affect their relative's lives. Eight admission agreements</p>

consent.		sighted were signed.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	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 provided opportunities for the family/enduring power of attorney (EPOA) to be involved in decisions. The resident files include information on residents' family/whānau and chosen social networks.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. Activities programmes included opportunities to attend events outside of the facility including activities of daily living, for example, shopping and attending cafés and restaurants. Interview with staff, residents and relatives informed residents are supported and encouraged to remain involved in the community and external groups. Relative and friends are encouraged to be involved with the service and care.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The organisational complaints policy stated that the village manager has overall responsibility for ensuring all complaints (verbal or written) are fully documented and investigated. There is an electronic complaint's register that included relevant information regarding the complaint. Documentation included follow-up letters and resolution were available. The number of complaints received each month is reported monthly to staff via the various meetings. There were six complaints received in 2017 (year to date) and five complaints from 2016. All the complaints documentation included follow-up letters and resolutions were completed within the required timeframes. Two of the complaints were received from the Health and Disability commission. These complaints were resolved and management changes including policy and procedures updates were implemented. Both complaints have been satisfactorily managed and closed. A complaints procedure is provided to residents within the information pack at entry. Feedback forms are available for residents/relatives in various places around the facility.
Standard 1.1.2: Consumer Rights During Service Delivery	FA	The service provides information to residents that include the Code, complaints and advocacy. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Residents and relatives interviewed identified they were well informed about the Code of Rights. Monthly

<p>Consumers are informed of their rights.</p>		<p>resident meetings provide the opportunity to raise concerns. An annual residents/relatives survey is completed. Advocacy and Code of Rights information is included in the information pack and are available at reception. An advocate from Age Concern attends residents' meetings bi-monthly.</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, residents' privacy and dignity. House rules and a code of conduct are signed by staff at commencement of employment. Contact details of spiritual/religious advisors are available. Resident files include cultural and spiritual values. Residents and relatives interviewed reported that residents are able to choose to engage in activities and access community resources. There is an elder abuse and neglect policy and staff education and training on abuse and neglect last occurred in February 2017.</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>	<p>FA</p>	<p>Summerset in the Sun has a Māori health plan that includes a description of how they achieve the requirements set out in the contract. The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. They value and encourage active participation and input of the family/whānau in the day-to-day care of the resident. At the time of the audit there were no residents that identified as Māori living at the facility. Māori consultation is available through the documented iwi links. Staff interviewed were able to describe how they can ensure they meet the cultural needs of Māori.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and</p>	<p>FA</p>	<p>An initial care planning meeting is carried out where the resident and/or whānau as appropriate/able are invited to be involved. Individual beliefs or values are further discussed and incorporated into the care plan. Six-monthly multidisciplinary team meetings occur to assess if needs are being met. Family are invited to attend. Discussion with relatives confirms values and beliefs are considered. Residents interviewed confirm that staff consider their culture and values.</p>

respect their ethnic, cultural, spiritual values, and beliefs.		
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Contracts and job descriptions include responsibilities of the position and ethics, advocacy and legal issues and staff sign a copy on employment. The orientation programme provided to staff on induction includes an emphasis on privacy and personal boundaries. The quality improvement meetings occur monthly and include discussions on professional boundaries and concerns as they arise. Management provide guidelines and mentoring for specific situations. Interviews with the village manager, care centre manager and registered nurses confirmed an awareness of professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	CI	<p>Residents and relatives interviewed spoke very positively about the care and support provided. Staff have a sound understanding of principles of aged care and state that they feel supported by the village manager, care centre manager and clinical nurse lead. 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 as well as other external aged care providers. There is a culture of ongoing staff development with an in-service programme being implemented. There is evidence of education being supported outside of the training plan. Services are provided at Summerset that adhere to the Health & Disability Services Standards and all approved service standards are adhered to. There are implemented competencies for caregivers and registered nurses including but not limited to: insulin administration, medication, wound care and manual handling. RNs have access to external training. There is a family suite within the care centre which mostly caters for families of end of life residents. The service has evidenced improved outcomes for residents following a management focus on staff education and staff engagement.</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>Residents and family members stated they were welcomed on entry and were given time and explanation about services and procedures. Family members interviewed also stated they are informed of changes in the health status of residents and incidents/accidents. Resident/relative meetings are held monthly with an advocate from Age Concern present at the meeting every two months. The village manager and the care centre manager have an open-door policy. The service produces a newsletter for residents and relatives. Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The service has policies and procedures available for access to interpreter services for residents (and their family/whānau). If residents or family/whānau have difficulty with written or spoken English, the interpreter services are made available.</p>

<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The service 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 certified for rest home level of care. On the day of the audit, there were 62 residents in total - 19 residents at hospital level including one respite resident and 43 residents at rest home level including 12 rest home residents in the serviced apartments (10 on the ground floor and two on level one). All residents were under the aged related contract.</p> <p>The Somerset Group Limited Board of Directors have overall financial and governance responsibility and there is a company strategic business plan in place.</p> <p>Somerset 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 operations manager (ROM). The quality plan is reviewed regularly throughout the year. There is a full evaluation at the end of the year. The 2016 evaluation was sighted. The village manager has been in the current role at Somerset for 18 months. The village manager (RN) is supported by a care centre manager/RN. The care centre manager has been in the position for 12 months and holds a postgraduate qualification in frontline management and has five years' experience in aged care management. The care centre manager is supported by the clinical nurse lead.</p> <p>Village managers and care centre managers attend annual organisational forums and regional forums over two days. The care centre manager attends clinical education (including advance care planning, interRAI updates, and DHB forums/provider meetings). There is a regional operations manager who is available to support the facility and staff. The village manager has attended at least eight hours of leadership professional development relevant to the role.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>During a temporary absence, the care centre manager will cover the manager's role. The regional operations manager and the Somerset clinical quality manager provide oversight and support. The audit confirmed the service has operational management strategies and a quality improvement programme to minimise risk of unwanted events.</p>

<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>Summerset in the Sun is implementing the organisation's quality and risk management system. There are policies and procedures being implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed on a regular basis. The content of policy and procedures are detailed to allow effective implementation by staff.</p> <p>The Summerset group has a 'clinical audit, training and compliance' calendar. The calendar schedules the training and audit requirements for the month and the care centre manager reports completion of requirements. Summerset in the Sun reporting to head office includes (but not limited to): complaints, staff turnover, meetings held, audits, quality indicators for infections, incidents and accidents, health and safety and projects.</p> <p>There is a meeting schedule including monthly quality improvement (full facility) meetings that includes discussion about clinical indicators (eg, incident trends, infection rates). Registered nurse meetings are held monthly. Informal caregivers' meetings are held at least fortnightly. Health and safety, quality and full staff meetings are held monthly, infection control and restraint are reported monthly with meetings occurring three-monthly. There are other facility meetings held such as kitchen and activities. An annual residents/relatives survey completed (October 2017) reports overall 98% feedback of experience being good or very good.</p> <p>The service is implementing an internal audit programme that includes aspects of clinical care. Issues arising from internal audits are developed into corrective action plans. Monthly and annual analysis of results is completed and provided across the organisation. There are monthly accident/incident benchmarking reports completed by the care centre manager that break down the data collected across the rest home and hospital and staff incidents/accidents. Infection control is also included as part of benchmarking across the organisation. Health and safety internal audits are completed. Summersets clinical and quality manager analyses data collected via the monthly reports and corrective actions are required based on benchmarking outcomes. Summerset has a data tool "Sway- the Summerset Way". Sway is integrated and accommodates the data entered. There is a health and safety and risk management programme in place including policies to guide practice. The activities coordinator is the health and safety representative (interviewed). There is a current hazard register. Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and</p>	<p>FA</p>	<p>Incident and accident data has been collected and analysed. Discussions with the service confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Seventeen resident related incident reports for September and October 2017 were reviewed (fifteen falls, one skin tear and one other category). All falls have a documented post fall assessment. All reports and corresponding resident files reviewed evidence that appropriate clinical care has been provided following an incident. 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</p>

<p>reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>programme and used for comparative purposes.</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 resources policies to support recruitment practices. A list of practising certificates is maintained. Eight staff files (one care centre manager, two RNs, one clinical nurse lead, one housekeeper, one recreational therapist, and two 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. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme includes documented competencies and induction checklists (sighted in staff files reviewed). Staff interviewed were able to describe the orientation process and believed new staff were orientated well to the service. There is an annual education plan that is outlined on the 'clinical audit, training and compliance calendar'. The plan is being implemented. A competency programme is in place with different requirements according to work type (eg, care assistants, registered nurse and kitchen). Core competencies are completed, and a record of completion is maintained on staff files as well as being scanned into 'Sway'.</p> <p>Staff interviewed were aware of the requirement to complete competency training and commented that the current education programme was comprehensive and interesting. Caregivers complete an aged care programme. There are 30 permanent caregivers employed, all have completed at least level two aged care qualifications.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The 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 lead works full time Sunday to Thursday.</p> <p>In the care centre, there is an RN on duty 24/7. There are six caregivers on morning shifts, six on the afternoon shifts and three on night shifts. An enrolled nurse is rostered to work one morning, and four afternoon shifts per week. The RN on duty provides oversight to the rest home residents in the serviced apartments.</p> <p>Two caregivers are on duty in the serviced apartments on a morning shift, and one on the afternoon shift and night shift to assist the twelve rest home residents.</p> <p>A staff availability list ensures that staff sickness and vacant shifts are covered. Caregivers interviewed</p>

		<p>confirmed that staff are replaced when off sick.</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 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. 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 and are kept in a locked cupboard. Care plans and notes were legible and where necessary signed (and dated) by a registered nurse. Entries are legible, dated and signed by the relevant care assistant or registered nurse including designation. Individual resident files demonstrate service integration. There is an allied health section that contained general practitioner notes and the notes of allied health professionals and specialists involved in the care of the resident.</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, including those at rest home level of care in serviced apartments have a needs assessment completed prior to entry that identifies the level of care required. The care centre manager or clinical nurse leader screens all potential enquiries to ensure the service can meet the required level of care and specific needs of the resident.</p> <p>Residents (three rest home and two hospital) and relatives (five rest home and two hospital) interviewed stated that they received sufficient information on admission and discussion was held regarding the admission agreement. The admission agreement reviewed aligns with a) - k) of the ARC contract.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>There is an exit discharge and transfer policy that describes guidelines for death, discharge, transfer, documentation and follow-up. All relevant information is documented and communicated to the receiving health provider or service. 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>	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. Registered nurses and an enrolled nurse are responsible for the administration of medications in the rest</p>

<p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>home/hospital care centre and complete annual medication competencies. Night shift caregivers' complete competencies for the checking and witnessing of medications as required. All medications (robotic rolls) were evidenced to be checked on delivery with any discrepancies fed back to the supplying pharmacy. Standing orders are not used. There were no residents self-medicating on the day of audit. The medication fridge temperature is checked daily and within the acceptable range. All medications are stored safely and within the expiry dates. Emergency stocks had been checked weekly. Eye drops had been dated on opening.</p> <p>Sixteen resident medication charts on the electronic medication system were reviewed (eight rest home and eight hospital). The medication charts had photograph identification and allergy status recorded. Staff recorded the time and date of 'as required' medications when administered.</p> <p>All 16 medication charts reviewed identified that the GP had reviewed the medication chart 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>	<p>FA</p>	<p>An external company is contracted for the provision of meals on-site. There is an eight-week seasonal rotating menu approved by the dietitian. The kitchen manager (interviewed) is notified of any changes to resident's dietary requirements. Resident likes/dislikes and preferences are known and accommodated with alternative meal options and vegetarian choice on the menu. Food is delivered in hot boxes to the care centre kitchenette where meals are served from the bain marie. Meals in a bain marie are delivered to the serviced apartment main dining area and plated meals in hot boxes to other areas. Texture modified meals, low fibre diets, dairy free, gluten free and food allergies are accommodated. The cook receives a dietary profile for each resident.</p> <p>The fridge and freezer have daily temperatures recorded. End cooked food temperatures and serving temperatures are taken and recorded daily. All foods are stored correctly, and date labelled. Cleaning schedules are maintained. Staff were observed wearing correct personal protective clothing in the kitchen. The chemical provider completes a functional test on the dishwasher monthly.</p> <p>Staff working in the kitchen have food handling certificates and chemical safety training. The site-specific food safety plan has been approved by the council.</p> <p>Residents commented positively on the meals provided. The kitchen manager receives feedback from resident meetings and surveys.</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</p>	<p>FA</p>	<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.</p>

consumer and/or their family/whānau is managed by the organisation, where appropriate.		
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>The initial support plan is developed with information gathered from medical and allied health notes, discharge summaries and information from the resident (if appropriate) and family members. Clinical risk assessments are completed on admission where applicable and reviewed six monthly as part of the interRAI assessment. Outcomes of risk assessment tools are used to identify the needs, supports and interventions required to meet resident goals. The interRAI assessment tool has been utilised for all residents.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>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. Care plans demonstrate service integration and include input from allied health practitioners.</p> <p>Short-term care plans were in use for changes in health status. These are evaluated regularly and either resolved or if an ongoing problem, added to the long-term resident centred care plan</p> <p>There is documented evidence of resident/family involvement in the care planning process. Residents/relatives interviewed confirmed they participate in the care planning process.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>When a resident's condition changes, the RN initiates a review and if required a GP or nurse specialist consultation. Family members interviewed state their relative's needs are met 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 wounds. Chronic wounds are linked to the long-term care plan. Evaluation comments were documented at each dressing change to monitor the healing progress. Weekly photographs record healing progress. The clinical nurse lead confirmed there was a wound nurse specialist and district nurse available as required for wound care advice.</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</p>

		<p>continence advice is available as needed.</p> <p>There are a number of monitoring forms and charts available for use including (but not limited to) pain monitoring, blood sugar levels, weight, food and fluid intake and charts, behaviour charts and neurological observations.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The service employs a fulltime diversional therapist (DT) in training and a part-time recreational therapist (RT) four days a week for 6.5 hours. The activity team coordinate and implement a six-day week programme Monday to Saturday. The DT (in training) has a current first aid certificate.</p> <p>The integrated rest home and hospital programme is planned a month in advance and includes set Summerset activities with the flexibility to add other activities of interest or suggestions made by residents. Rest home residents in the serviced apartments may choose to join in the care centre or village activity programme. Activities meet the recreational needs of both resident groups and includes (but not limited to): life discussions and chats, newspaper reading, men's' club, board games, manicures, baking, trivia and board games. Volunteers are involved in providing activities. Festive occasions and theme days are celebrated. The DT and RT are on together for some days of each week and are able to provide a choice of activities on these days including "just the two of us" one-on-one time. Community involvement includes entertainers, library service, SPCA and animal therapy and visits to the local primary school. The activity team have several walking groups dependant on the resident's mobility, including wheelchairs walks and lazy boy chair walks.</p> <p>Residents are encouraged to maintain their former links in the community. Church services are held regularly.</p> <p>Monthly meetings provide an opportunity for residents to feedback on the programme. Newsletters are sent out to families informing them of upcoming events.</p> <p>The DT (in training) is involved in the multidisciplinary review, which includes the review of the activity plan.</p>
<p>Standard 1.3.8: Evaluation</p> <p>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 review of resident centred care plans. All initial care plans were evaluated by the registered nurses within three weeks of admission. Written evaluations were completed six monthly or earlier for resident health changes in all files reviewed and documented if the resident goals have been met or unmet. The long-term resident centred care plans reviewed had been updated to reflect current needs/supports required. There is written evidence of multidisciplinary (MDT) team involvement in the reviews including input from the GP, allied health professionals involved in the resident's care, caregivers, activity team and resident/relative. 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.</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 sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The service provided an example of where a resident's condition had changed, and the resident was reassessed for a higher level of care from respite to rest home level of care.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Safety datasheets were readily accessible for staff. Chemicals were stored safely throughout the facility. All chemicals were labelled correctly with manufacturer labels. 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>
<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 20 January 2018 (communal spaces) and 27 January 2018 (care centre and apartments). Building warrant of fitness checks are underway. There is a full-time property manager who oversees the property and gardening team for the village and care centre and is available on call for facility matters. Maintenance and repairs systems are in place with requests generated through the on-line system. Planned maintenance (monthly works orders) are completed monthly. Hot water temperatures have been tested and recorded monthly with readings below 45 degrees Celsius. All electrical equipment has been tested and tagged annually. Clinical equipment has had functional checks/calibration annually. Preferred contractors for essential services are available 24/7.</p> <p>The care centre is located on the first floor. The serviced apartment building has two floors with lift access and</p>

		<p>connecting air bridge to the care centre. There is external access from the ground floor of the apartment building to the communal spaces such as the café.</p> <p>Corridors are wide in all areas to allow residents to pass each other safely. There is safe access to all communal areas and outdoor areas. The care centre has an outdoor balcony with seating and shade. The external areas and gardens are well maintained.</p> <p>The care staff and registered nurses (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>Visual inspection evidences toilet and shower facilities are of an appropriate design to meet the needs of the residents. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. Resident rooms (including serviced apartments) have ensuite bathrooms. There are four resident rooms that share communal shower/toilets that are in proximity to the bedrooms. There are adequate numbers of communal toilets located near the communal areas. Communal toilet/shower facilities have a system that indicates if it is engaged or vacant. Showers have privacy curtains in place. Residents interviewed stated staff are respectful of their privacy when carrying out hygiene 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>There are 58 single rooms and one double room in the care centre. The serviced apartments certified for rest home level of care are all one-bedroom units with a separate lounge/kitchenette and full ensuite. There is adequate room to safely manoeuvre mobility aids and transferring equipment such as hoists in all the resident bedrooms. The doors are wide enough for ambulance trolley access. Residents and families are encouraged to personalise their rooms as viewed on the day of audit.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment,</p>	FA	<p>Communal areas within the care centre include a large main lounge that can accommodate rest home and hospital level residents and where most activities take place. There are two family rooms in the care centre with tea making facilities. The dining room in the care centre is spacious. There are seating alcoves within the facility and an outdoor covered balcony. The communal areas are easily accessible for residents. There are</p>

<p>Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>		<p>recreational areas including a café in the main building. There is a separate spacious dining area for the serviced apartments as well as a smaller dining area in the upstairs and downstairs serviced apartment building. All communal areas including the outdoor areas are easily accessible.</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 are two designated cleaning staff on duty in the care centre each day except Saturdays when there is one cleaner on duty. A designated laundry person is based in the service area on the ground floor. A chute is used to deliver dirty laundry from the care centre to the downstairs laundry. The laundry is well equipped, and all machinery has been serviced regularly. There is a sluice area in the laundry with personal protective equipment available. The laundry has defined clean/dirty areas and an entry and exit door with adequate ventilation.</p> <p>Cleaning trolleys sighted were well equipped and are kept in designated locked cupboards when not in use. External (chemical provider) and internal audits monitor the effectiveness of laundry and cleaning processes.</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>Appropriate training, information, and equipment for responding to emergencies is provided. There is an approved evacuation plan (letter dated 20 December 2013). Fire evacuations are held six monthly and the last drill was completed 21 September 2017. There is a civil defence and emergency plan in place. The civil defence kit is readily accessible. The facility is well prepared for civil emergencies and has emergency lighting, a store of emergency water and a gas BBQ for alternative cooking. Emergency food supplies sufficient for three days are kept in the kitchen. Hoists have battery back-up. Oxygen cylinders are available. At least three days stock of other products such as incontinence products and PPE are kept. There is a store cupboard of supplies necessary to manage a pandemic. The call bell system is available in all areas with indicator panels in each area. During the tour of the facility residents were observed to have easy access to the call bells and residents interviewed stated their bells were answered in a timely manner. There is a first aid trained staff member on duty 24 hours.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided</p>	<p>FA</p>	<p>Visual inspection evidences that the residents have adequate natural light in the bedrooms and communal rooms, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. There is ceiling heating throughout the building that can be individually thermostat controlled within the resident's rooms.</p>

with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.		
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The infection control programme is appropriate for the size and complexity of the service. There is an infection control responsibility policy that includes responsibilities for the infection control officer. The infection control officer 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 officers. The quality, health and safety and staff meetings include discussion of infection control matters.</p> <p>Visitors are asked not to visit if they are unwell. Influenza vaccines are offered to residents and staff.</p> <p>Summerset in the Sun experienced two gastro outbreaks in July and August 2017. Notifications to public health and DHB and appropriate documentation including infection log, education sessions for staff, meeting minutes and an outbreak debrief were sighted for each event.</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 officer attends an annual Summerset training day for infection control officers. The infection control officer has also attended external training including outbreak management, surveillance and benchmarking. The infection control committee consists of the care centre manager and infection control officer. The committee meet there monthly. The infection control officer reviews infections each month and provides a report to the village manager for discussion at the monthly quality meetings. All infection events are forwarded to head office for benchmarking.</p> <p>The facility has access to an infection control nurse specialist at the DHB, external infection control consultant, public health, laboratory, GPs and expertise within the organisation.</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</p>	FA	<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 annually with input from infections control officers. The infection control policies link to other documentation and cross reference where appropriate.</p>

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.		
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control officer 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. Resident education occurs as part of providing daily cares. Care plans 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 Sway electronic system. The infection control officer provides infection control data, trends and relevant information to the infection control committee and clinical/quality meetings. Areas for improvement are identified and corrective actions are developed and followed up. The facility is benchmarked against other Summerset facilities of similar size and benchmarking results are fed back to the infection control officer and used to identify areas for improvement. Infection control audits are completed, and corrective actions are signed off. Surveillance results are used to identify infection control activities and education needs within the facility.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. The policy includes comprehensive restraint procedures. A registered nurse is the restraint coordinator with a job description that defines the role and responsibilities. The policy identifies that restraint is used as a last resort. There were no residents requiring the use of a restraint and one resident using an enabler at the time of audit. Enablers are voluntary and the least restrictive option. The resident and family have been provided with information on use of enablers and a voluntary a consent form signed. Use of enabler and risks were documented in the long-term care plan of the one enabler file reviewed.

<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>CI</p>	<p>Restraint and behaviours are regularly reviewed. Internal audits review practises. A restraint-free environment is a 2017 goal for Summerset in the Sun. The service has been restraint free since May 2017. Staff receive training around restraint minimisation that includes annual competency assessments.</p>

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>Summerset in the Sun is to be commended for improvements made to the education programme during 2016 and 2017 as a result of residents and staff feedback and a number of quality improvements have been made with positive results. The required standard</p>	<p>The service demonstrated a number of examples of good practice including (but not limited to) (i) A very strong organisational culture of respect, teamwork and excellent communication. (ii) Summerset in the Sun has through an audit process, identified staff requiring additional education and employed a dedicated educator (RN) to assist with orientation completion, competency testing and Careerforce qualifications. They now have 100 percent of care and cleaning staff enrolled and actively working on Careerforce qualifications. Summerset staff have consistently demonstrated high attendance at in-service education sessions for the last year.</p> <p>On interview six caregivers were enthusiastic and positive about the support and opportunities for further learning. The results of a staff engagement survey completed in November evidence a 79% engagement up 20% from the previous survey in 2015. The resident’s satisfaction survey</p>

		has been exceeded around good practice.	in November 2017 reports 98% satisfaction with staff personal care and communication. This result is up from 79% for 2016. The last six months have evidenced a 70% reduction in care related complaints from the previous six months.
<p>Criterion 2.2.5.1</p> <p>Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:</p> <p>(a) The extent of restraint use and any trends;</p> <p>(b) The organisation's progress in reducing restraint;</p> <p>(c) Adverse outcomes;</p> <p>(d) Service provider compliance with policies and procedures;</p> <p>(e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;</p> <p>(f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;</p> <p>(g) Whether changes to policy, procedures, or guidelines are required; and</p> <p>(h) Whether there are additional education or training needs or changes required to existing education.</p>	CI	The service reviewed the use restraint at the beginning of 2017 and developed an action plan that has achieved a restraint free environment for the last seven months.	The service developed an action plan to reduce the use of restraints and become restraint free. This included a) purchasing of super low beds for resident at risk of requiring restraint, b) identifying residents who were using the bedrails to assist them to mobilise in bed and providing an alternative piece of equipment that was not a restraint such as a monkey bar, c) meeting with families, providing information and discussion around restraints and gaining consent for trial of removal of restraint and d) education for staff and keeping them informed on progress towards the goal of restraint free environment. In February 2017 there were six residents using restraint and two in March and April. New super low beds arrived and were put in place in April 2017. From May 2017 to November 2017 there have been no restraints in use and one enabler. The service has been successful in achieving its goal of a restraint free environment.

End of the report.