Summerset Care Limited - Summerset at Karaka

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 at Karaka
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 7 August 2018 End date: 8 August 2018

Proposed changes to current services (if any): There is a room in the care centre which was previously designated as a doctor's room and is next to the nurse's station has been converted to be a resident room. The room has been refurbished and the service is planning to use this room for short stay residents. It does not have a toilet ensuite, but there is a communal toilet adjacent to the room and a shower within close walking distance. The room has a sink and call bell. The room is an appropriate size with vinyl flooring. Bed numbers in the care centre will increase from 49 beds to 50 beds.

Total beds occupied across all premises included in the audit on the first day of the audit: 57

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Summerset at Karaka provides rest home and hospital level care for up to 50 residents in the care centre and rest home level care for up to 20 residents in the services apartments. On the day of the audit there were 57 residents. 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 and a clinical nurse leader. An induction and in-service training programme are in place to provide staff with appropriate knowledge and skills to deliver care.

This certification identified areas for improvement around the quality programme.

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.

The facility provides care in a way that focuses on the individual resident. There is a Māori health plan and cultural safety policy supporting practice. Cultural assessment is undertaken on admission and during the review process. The service functions in a way that complies with the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and related services is readily available to residents and families. Policies are available that support residents' rights. Care plans accommodate the choices of residents and/or their family. 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.		Some standards applicable to this service partially attained and of low risk.

Summerset at Karaka as a documented quality and risk management system. Annual surveys and resident meetings provide residents and families with an opportunity for feedback about the service. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care. There is a staffing policy in place.

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 a comprehensive pack available for residents and families/whānau at entry. Assessments, resident care plans, and evaluations were completed by the registered nurses within the required timeframes. Risk assessment tools and monitoring forms were available and implemented. Resident care plans reviewed were individualised and included allied health professional involvement in resident care. Recreational therapists and 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.

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.

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 compliance certificate for public use. 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.

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 were no residents requiring the use of a restraint or enabler at the time of audit.

Infection prevention and control

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

The infection control programme is appropriate for the size and complexity of the service. The infection control coordinator (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. This included audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Summerset facilities.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	44	0	1	0	0	0
Criteria	0	90	0	1	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The service has a range of policies and procedures to ensure that residents rights are protected. Discussions with 11 staff (four caregivers, two registered nurses (RN) and two activities coordinators confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Four residents (one rest home and three hospital level of care) and four relatives (three hospital and one rest home) were interviewed and confirmed the services being provided are in line with the Code. Observation during the audit confirmed this in practice.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed	FA	Informed consent processes were discussed with residents and families on admission. Written general and specific consents were evident in the eight resident files (two rest home residents including one in the serviced apartment and six hospital level residents including one young person's disability). Caregivers and the care centre manager interviewed, confirmed consent is obtained when delivering cares. Resuscitation orders had been appropriately signed by the resident and general practitioner (GP). Advance care plans were signed for separately. Discussion with family members identifies that the service actively involves them in decisions that affect their relative's lives. Admission agreements for all residents were sighted.

consent.		
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 provides 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 12 complaints received in 2018 (year to date) and ten complaints from 2017. Follow-up letters and resolutions were completed within the required timeframes. One recent complaint remains open, pending investigation. 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 Consumers are informed of their rights.	FA	The service provides information to residents that includes 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 are well informed about the Code of Rights. One to three monthly 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 is invited to attend resident's meetings.

Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	Staff interviewed were able to describe the procedures for maintaining confidentiality of resident records, resident's 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 June 2018.
Standard 1.1.4: Recognition Of Māori Values And Beliefs 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.	FA	Summerset at Karaka has a Māori health plan that includes a description of how they achieve the requirements set out in the contract. There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. At the time of audit there were no residents who identified as Māori. A review of the resident's file evidenced that cultural and spiritual values and needs were addressed. The resident was interviewed and expressed that her cultural and spiritual needs were respected and met. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with disability and other community representative groups as requested by the resident/family. Cultural needs are addressed in the care plan. Staff interviewed were able to describe how they can ensure they meet the cultural needs of Māori.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	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 confirmed values and beliefs are considered. Residents interviewed confirmed that staff consider their culture and values.
Standard 1.1.7:	FA	Staff job descriptions include responsibilities and staff sign a copy on employment. The quality improvement

Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.		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, clinical nurse leader, regional quality manager and registered nurses confirmed an awareness of professional boundaries. Caregivers were knowledgeable regarding professional boundaries.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	Residents and relatives interviewed spoke very positively about the care and support provided. Staff have a sound understanding of principles of aged care and stated that they 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 at Karaka that adhere to the Health & Disability Services Standards and all approved service standards are adhered to. There are implemented competencies for caregivers and RNs including (but not limited to): insulin administration, medication, wound care and manual handling. RNs have access to external training. A strong teamwork approach encouraged by positive leadership and regular team building events, fosters a culture of good practice.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents and family members interviewed 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 three 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.
Standard 1.2.1: Governance	FA	Summerset at Karaka provides rest home and hospital (geriatric and medical) level care for up to 50 residents in the care centre and rest home level care across 20 certified serviced apartments. On the day of the audit, there

The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.		were 57 residents. There were 50 residents in the care centre (dual purpose beds), including 14 residents at rest home level care and 36 residents at hospital level care (including one younger person - disabled). All other residents were under the age care contract. There were seven residents at rest home level of care spread across the three floors of serviced apartments. A further room in the care centre was verified at this audit as suitable to provide rest home or hospital level care (this room was already in use). The room was previously designated as a doctor's room and is next to the nurse's station. The room has been refurbished and the service is planning to use this room for short stay residents. It does not have a toilet ensuite, but there is a communal toilet adjacent to the room and a shower within close walking distance. The room has a sink and call bell. The room is an appropriate size with vinyl flooring. Bed numbers in the care centre will increase from 49 beds to 50 beds. The Summerset Group Limited Board of Directors have overall financial and governance responsibility and there is a company strategic business plan in place. Summerset at Karaka has a site-specific business plan and goals that is 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 2017 evaluation was sighted. The village manager has been in the current role at Summerset since 2013. The village manager is supported by a care centre manager (RN). The care centre manager has been in the position for fifteen months and has previous experience in health care auditing. The care centre manager is supported by a clinical nurse lead who is new to the role. Village managers and care centre managers attend annual organisational forums and regional forums over two days. The care centre manager attends clinical education, forums/provider meetings at the district health board. There is a regional operations manager who is available to support the facility and staff. The village manager and care centre management has attended at least eight hours of leadership professional development relevant to the role.
Standard 1.2.2: Service Management 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	FA	During a temporary absence, the Summerset roving care centre manager will cover the manager's role. The regional operations manager and the 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.

services to consumers.		
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Low	Summerset at Karaka has a documented 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. 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 is responsible for confirming completion as required to head office. The calendar includes (but is not limited to); monthly quality improvement, weekly caregiver and monthly registered staff meetings that include discussion about clinical indicators (eg, incident trends, infection rates). Health and safety, infection control and restraint meetings are scheduled monthly. Summerset Karaka meetings have not occurred as scheduled in the planner. The Summerset internal audit schedule programme includes, all aspects of clinical care, environmental, organisational and human resource management. The service is not implementing the internal audits as scheduled. Where audits have occurred, 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 via VCare 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 uses a new system, SharePoint, to extract information from VCare. SharePoint collates and analyses the data and provides clear reporting. There is a health and safety and risk management programme in place including policies to guide practice. The maintenance manager is the health and safety representative (interviewed). The service addresses health and safety by recording hazards and near misses into a designated electronic database, sharing of health and safety information and actively encourage staff input and feedback. The service ensures that all new staff and any contractors are inducted to the health and safety programme. The health and safety programme has been designed around the new legislation. Falls prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned,	FA	Incident and accident data has been collected and analysed. Ten resident related incident reports for May, June and July 2018 were reviewed (five falls, four skin tears and one other category). 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,

or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.		monitoring and corrective action to minimise and debriefing. Data is linked to the organisation's benchmarking programme and used for comparative purposes. Discussions with the service confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. A section 31 has been submitted for a PI.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	There are human resources policies and an electronic system "snap hire" to support recruitment practices. A list of practising certificates is maintained. Eight staff files (one care centre manager, two RNs, one activities coordinator, four 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 files of newly appointed staff). Staff interviewed were able to describe the orientation process and believed new staff were adequately orientated to the service. There is an annual education plan that is outlined on the 'clinical audit, training and compliance calendar'. Compulsory training includes continence management, nutrition/dietary, manual handling, pressure area care, pain management, rights/advocacy, wound management, and hoist training. The annual training programme has not been consistently implemented as planned, although all mandatory sessions have been implemented as required at the time of this audit. 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. Care staff interviewed were aware of the requirement to complete a minimum of level two Careerforce training. Caregivers complete an aged care programme. There are 32 permanent caregivers employed. All staff are required to complete level 2 Careerforce as part of the orientation. All current caregivers have either completed Careerforce qualifications or are actively working towards it. Staff communication is actively promoted through the use of a new initiative on line application called Crew. Crew provides an open forum for communication for all staff. With the app, staff can communicate around rosters, available shifts, reminder of education and meetings and to provide feedback on service delivery.
Standard 1.2.8: Service Provider Availability Consumers receive	FA	The village manager and care centre manager work 40 hours per week Monday to Friday and are available on call at all times for any emergency issues or clinical support. The clinical nurse lead works full time Sunday to Thursday.

timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.		In the care centre, there are two RNs on duty on the morning and afternoon shifts and one on the night shift. They are supported by eight caregivers on morning shifts (five full shifts and three short shifts), seven on the afternoon shifts (four full shifts and three short shifts) and two on the night shifts (full shift). The RN on duty provides oversight to the rest home residents in the serviced apartments. There is one caregiver on duty in the serviced apartments on a morning shift and afternoon shift, and one on the night shift to assist the seven rest home residents. Staff carry pagers that alert them to call bells and walkie talkies, so they can communicate effectively. A staffing levels and skills mix policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery. Interviews with residents and relatives confirmed that staffing levels are sufficient to meet the needs of residents. A staff availability list ensures that staff sickness and vacant shifts are covered. Caregivers interviewed confirmed that staff are replaced when off sick. Interviews with residents and relatives confirmed that staffing levels are sufficient to meet the needs of residents.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	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 by being held in a locked office. 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.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	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 a) - k) of the ARC contract.
Standard 1.3.10: Transition, Exit,	FA	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

Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.		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.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	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 administer medications with senior caregivers checking when required. Medication education and medication competencies have been completed annually. All medications (in robotic rolls) were evidenced to be checked on delivery with any discrepancies fed back to the supplying pharmacy. There were two rest home residents self-medicating with current self-medication competencies (both for inhalers). All medications were stored correctly in the care centre medication room with provisions (additional storage compartments) being made since the previous audit so all medications are stored appropriately and safely. The controlled drug register evidenced being accurately maintained with weekly checks by two registered nurses and six monthly by the pharmacist (June 2018). An entry is made in the register if a controlled drug is returned to the pharmacy and all other no longer required are returned to the pharmacy daily Monday to Friday. Medication is managed for all areas from the one treatment room. They have three trolleys which go out. All eye drops were dated on opening. The medication fridge is monitored daily. All medications were within the expiry dates. Sixteen 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. All 'as required' medications had an indication for use. All medication charts had been reviewed by the GP three monthly.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	The service has a contracted company for the provision of all meals on-site for the care centre, serviced apartments and café. The service has a registered food control plan that is yet to be audited. Food service staff have completed food safety. Two of the three chefs are on duty each day covering from 7.00 am to 6.30 pm and are supported by kitchenhands. The four-weekly menu has been reviewed by a Summerset nutritionist (winter menu reviewed May 2018). The menu provides pureed/soft, vegetarian and diabetic desserts. Food is delivered in hot boxes to the kitchenette bain maries in the care centre (there is one main dining room). The head chef receives resident profiles. Resident dislikes are known and plated/labelled in the kitchen before delivery. The head chef is notified of any changes to dietary requirements of weight loss. Smoothies and fortified foods are provided on request. The fridge, freezer, end-cooked food temperatures and serving temperatures are taken and recorded. All foods are stored correctly, and date labelled. Cleaning schedules are

		maintained. Staff were observed wearing correct personal protective clothing. Residents have the opportunity to feedback on meals through direct feedback (the chef serves the meals) and resident meetings.
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 and referring agency for all long-term and short-stay residents. Risk assessments are 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 of permanent residents. The interRAI assessment tool has been utilised six monthly for long-term residents.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Care plans for long-term residents describe the individual support and interventions required to meet the resident goals. Initial risk plans are developed on admission (as applicable) to alert staff to any resident risks such as falls. The long-term 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. These are evaluated regularly and either resolved or if an ongoing problem, added to the long-term care plan. There is documented evidence (care planning consultation record) of resident/family involvement in the care planning process. Residents/relatives interviewed confirmed they participate in the care planning process. Eight of eight files reviewed showed documented evidence to support the residents' current needs. This included the use of an acute support plan for a resident following a fall, short-term care plans for wounds, infections, pain, constipation, wandering, aggression and the use of a GPS tracker.

Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	When a resident's condition changes, the RN initiates a review and if required a GP visit. Relatives interviewed stated 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 stated their needs are being met. Interventions had been implemented/documented (in one case advice from an allied health professional was not fully followed due to lack of resident cooperation – a compromise was met). Adequate dressing supplies were sighted. Initial wound assessments with ongoing wound evaluations and treatment plans were in place for 31 residents with wounds of which 21 were skin tears (five rest home and 16 hospital). The balance of wounds were surgical lesions and chronic wounds. Photographs and evaluations demonstrate progress to healing. There were no pressure injuries. The RNs attended a wound symposium in February 2018 and they can refer residents to the Mercy Ascot wound clinic. 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. There are a number of monitoring forms available for use. Skin tear rates were identified as high. This had been identified by the facility. There had been 47 wounds in May 2018, 53 in June, 27 in July and on audit in August there were 31. Quality improvement meeting minutes identified actions to be taken (June 2018 identified that treatment plans were not consistently followed – any changes to the plan were now required to be approved by the CNL) and (July 2018 noted skin tears and falls were high and a number actions were implemented to reduce, for example, posters to alert staff, increase the use of sensor mats, purchase and use limb protectors, prompt call bell response and escorting residents at risk when walking) and the registered nurses meeting (July 2018 identified that a STCP was to be done for all wounds as well as the wound plan)
Standard 1.3.7: Planned Activities 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.	FA	The service employs three recreational therapists who work 58 hours in total covering seven days a week. The three recreational therapists have all been recently employed and have a range of skill areas, one is an overseas trained RN with a level 4 certificate and another has qualifications and has worked with special needs individuals for 18 years. The three are all commencing their diversional therapy training. They are supported by volunteers to implement the integrated activity programme. Residents in the serviced apartments are invited to join in the rest home activity programme. The programme is varied and provides group and individual activities to meet the hospital and rest home resident's recreational preferences and interests. One-on-one contact is made with residents who are unable, to or choose not to participate in group activities. Assistance has been given by the diversional therapists from two other group homes to assist in the recreational therapists learning their role. Activities include (but are not limited to); exercises, walks, word games and quizzes, board games, baking, movies, sing-a-longs and happy hours. Community visitors include church visitors, entertainers, schools,

		mothers and babies, and pet therapy. There are weekly outings and drives into the community (recently recommenced since the recreational therapists have undertaken competencies to take the van out). Resident meetings are held two monthly and provide an opportunity for residents to feedback on the programme. The recreational therapists are involved in the multidisciplinary reviews, which includes the review of the activity plan. Residents and relatives spoke positively about the activities 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 long-term resident care plans against resident goals. 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. There is evidence of multidisciplinary (MDT) team involvement in the reviews including input from the GP, RN, DT, physiotherapist 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. The service provided examples of where a resident's condition had changed, and the resident was reassessed 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	FA	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. 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.

a result of exposure to waste, infectious or hazardous substances, generated during service delivery.		
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	Summerset at Karaka is three levels with the serviced apartments on the ground floor and third floor. The care centre is on the second floor. The building has a building warrant of fitness that expires 31 August 2018. A maintenance person who works in the care centre and retirement village (also available on-call) is responsible for on-site maintenance. Monthly work orders are generated from head office and populated monthly. Orders cover all aspects of proactive maintenance. An on-line works order is generated for any maintenance requests and signed off when completed. All electrical equipment has been tested and tagged (October 2017). Clinical equipment has had functional checks/calibration completed October 2017 and June 2018. Hot water temperatures have been tested and recorded monthly with readings below 45 degrees Celsius. Random call bells are checked monthly. 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. Outdoor areas provide seating and shade. The caregivers (interviewed) stated they have all the equipment required to safely provide the care documented in the care plans. A further room in the care centre was also verified as part of this audit as suitable to provide rest home or hospital level care. The room was previously designated as a doctor's room and is next to the nurse's station. The room has been refurbished and the service is planning to use this room for short stay residents. It does not have a toilet ensuite, but there is a communal toilet adjacent to the room and a shower within close walking distance. The room has a sink and call bell. The room is an appropriate size with vinyl flooring.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance	FA	All rooms are single. Seven resident rooms share communal toilet/showers with privacy locks. All other resident rooms have ensuites. The 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 shared areas with privacy locks. Hot water temperatures are undertaken by the maintenance person and action taken if not within regulations. Resident interviewed confirmed the care staff respect their privacy when attending to their personal cares.

with personal hygiene requirements.		
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	There is adequate room to safely manoeuvre mobility aids and transferring equipment such as a hoist, as needed for cares and transfer of residents. 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.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	Communal areas within the facility include a large main lounge and adjacent dining room with kitchenette. There is also a smaller lounge and two-family rooms. There are several seating alcoves within the facility. The communal areas and outdoors are easily accessible for residents.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	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 (the personal laundry is done at night by one of the serviced apartment carers). The laundry is on the ground floor with a chute for the delivery of laundry from the care centre. There is a defined clean/dirty area. The laundry facility is well equipped, and all machinery has been serviced. There are dedicated cleaning staff on duty daily. Cleaning trolleys sighted were well equipped and have locked chemical boxes. The trolleys are kept in designated locked cupboards when not in use. There are safety datasheets and product sheets available. All chemicals are dispensed through an auto dispenser. Internal audits monitor the effectiveness of laundry and cleaning processes (link 1.2.3.6). The chemical provider monitors the laundry and cleaning processes for effectiveness. Cleaning and laundry staff have completed chemical safety training.

Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	The building has an evacuation scheme approved 22 March 2017. There are emergency and civil defence plans to guide staff in managing emergencies and disasters. Emergencies, first aid and cardiopulmonary resuscitation is included in the mandatory in-service programme. There is a first aid trained staff member on every shift. Summerset Karaka has an approved fire evacuation plan and fire drills occur six-monthly. The kitchen has electric and gas cooking facilities and there are barbeques available in the event of power failure. There are two civil defence supplies on each level of the building. There are sufficient food supplies and water tanks hold enough water for use in a civil defence emergency. Call bells were evident in resident's rooms, lounge areas and toilets/bathrooms. The facility is secured at night.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	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 (a resident and a relative commented that in the summer period the facility can be too warm – this was raised at audit with management who were aware of the issue and were undertaking investigations and actions to remedy this). To date they had already put in some blinds to reduce the heat issue. There is central heating throughout the facility. Resident rooms have an overhead ceiling panel which is temperature controlled in each room.
Standard 3.1: Infection control management 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.	FA	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 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 coordinators. The facility meetings include a discussion of infection control matters. Visitors are asked not to visit if they are unwell. Influenza vaccines are offered to residents and staff. Karaka has not experienced an outbreak since the last audit. The village manager, care centre manager and infection control coordinator were familiar with notification requirements.
Standard 3.2: Implementing the infection control	FA	The infection control coordinator attends an annual Summerset training day for infection control coordinators. The infection control coordinator also attended external training. The infection control committee includes a representative from each department. The infection control committee meets quarterly and infection events are

programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.		forwarded to head office for benchmarking. 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.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	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 were reviewed last in September 2017. The infection control policies link to other documentation and cross reference where appropriate.
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. Training on outbreak management and hand hygiene was last held in May 2017. Resident education occurs as part of providing daily cares. Care plans include ways to assist staff in ensuring this occurs.
Standard 3.5:	FA	The infection control policy includes a surveillance policy including a surveillance procedure, process for

Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.		detection of infection, infections under surveillance, outbreaks and quality and risk management. Infection events are entered into VCare and extracted monthly into share point electronic system. The infection control coordinator provides infection control data, trends and relevant information to the infection control committee and clinical/quality meetings (link1.2.3.6). 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 coordinator and used to identify areas for improvement. Infection control audits are completed, and corrective actions are signed off (sighted). 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 are policies around restraints and enablers. There were no residents requiring the use of a restraint or an enabler at the time of audit. Staff receive training around restraint minimisation that includes annual competency assessments.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	Summerset provides a documented calendar which schedules staff and resident meetings and internal audits for the full year. Some of the scheduled meetings at Karaka have been held, but not as scheduled and at intervals longer than planned. Clinical meetings have been held infrequently.	i) Care staff, full staff, resident, clinical, infection control, health and safety and restraint meetings have not occurred at scheduled times. ii) Meeting minutes do not fully document attendees and topics discussed. iii) Internal audits have not been completed as scheduled.	i) Ensure meetings occur at scheduled frequencies. ii) Ensure meeting minutes fully document attendees and topics discussed. iii) Ensure internal audits are

				implemented as scheduled. 90 days

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.

No data to display

End of the report.