

# Summerset Care Limited - Summerset Mountain View

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## Introduction

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

The audit has been conducted by 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:

<b>Legal entity:</b>	Summerset Care Limited
<b>Premises audited:</b>	Summerset Mountain View
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 21 August 2018 End date: 22 August 2018
<b>Proposed changes to current services (if any):</b>	At present one of the larger rooms in the care centre is being occupied by a married couple. This room was verified as suitable as a double-room for a married couple.
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	57



# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Summerset Mountain View provides rest home and hospital (medical and geriatric services) level care for up to 72 residents, including 20 residents at rest home level care across the serviced apartments. At the time of the audit there were 57 residents in total.

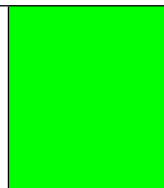
This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, family, management,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

The service is managed by a village manager who has been in the role for four years. The village manager is supported by a care centre manager who has been in the position for two years. The care centre manager is supported by the clinical nurse leader who has been in the role for eight months. Management are supported by a regional operations manager and regional quality manager. The residents and relatives interviewed spoke positively about the care and support provided.

There were no areas for improvement identified at this audit.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.

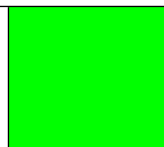


Standards applicable to this service fully attained.

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.



Standards applicable to this service fully attained.

Summerset Mountain View implements a quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to include monthly quality improvement meetings. 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.

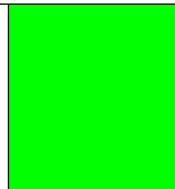


Standards applicable to this service fully attained.

There is an admission package available prior to or on entry to the service. Registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family input. Care plans viewed demonstrate service integration and are reviewed at least six monthly. Resident files include medical notes by the contracted general practitioners and visiting allied health professionals. Medication policies reflect legislative requirements and guidelines. Registered nurses and senior caregivers are responsible for the administration of medicines. Medication charts are reviewed three monthly by the GP. The diversional therapist implements the activity programme to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations. All meals are cooked on site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated.

## 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.

Chemicals are stored safely throughout the facility. Appropriate policies and product safety charts are available. The building holds a current warrant of fitness. There are six rooms which share communal showers/toilets. All other rooms have ensuites. External areas are safe and well maintained with shade and seating available. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are monitored through the internal

auditing system. 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.

## Restraint minimisation and safe practice

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

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. A registered nurse is the infection control coordinator who is responsible for the collation of infections and orientation and education for staff. There is a suite of infection control policies and guidelines to support practice. Information

obtained through surveillance is used to determine infection control activities and education needs within the facility. There have been no outbreaks since the last audit.

## Summary of attainment

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

<b>Attainment Rating</b>	<b>Continuous Improvement (CI)</b>	<b>Fully Attained (FA)</b>	<b>Partially Attained Negligible Risk (PA Negligible)</b>	<b>Partially Attained Low Risk (PA Low)</b>	<b>Partially Attained Moderate Risk (PA Moderate)</b>	<b>Partially Attained High Risk (PA High)</b>	<b>Partially Attained Critical Risk (PA Critical)</b>
<b>Standards</b>	0	50	0	0	0	0	0
<b>Criteria</b>	0	101	0	0	0	0	0

<b>Attainment Rating</b>	<b>Unattained Negligible Risk (UA Negligible)</b>	<b>Unattained Low Risk (UA Low)</b>	<b>Unattained Moderate Risk (UA Moderate)</b>	<b>Unattained High Risk (UA High)</b>	<b>Unattained Critical Risk (UA Critical)</b>
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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	Discussions with nine care staff (five caregivers including one that works in the serviced apartments, three registered nurses (RN) including the clinical nurse leader and one diversional therapist) confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Six residents (four rest home and two hospital) and four relatives (four 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 consent.	FA	The service has in place, a policy for informed consent. Completed resuscitation consent forms were evident on all resident files reviewed (three rest home, including one serviced apartment resident and five hospital, including one palliative care and one ACC resident). General consent forms were evident on files reviewed. Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for entering rooms, and personal care. Enduring power of attorney evidence is filed in the residents' charts where required.
Standard 1.1.11: Advocacy And	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

<p>Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>		<p>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.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. Activities programmes include opportunities to attend events outside of the facility including activities of daily living, for example, shopping and attending cafes and restaurants. Interview with staff, residents and relatives informed residents are supported and encouraged to remain involved in the community and external groups. Relatives and friends are encouraged to be involved with the service and care.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The organisational complaints policy states that the village manager has overall responsibility for ensuring all complaints (verbal or written) are fully documented and investigated. 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. There is an electronic complaint's register that includes relevant information regarding the complaint. The number of complaints received each month is reported monthly to staff via the various meetings. There have been 10 complaints received relating to the care centre since the last audit. The complaints reviewed included follow-up meetings and letters, and resolutions were completed within the required timeframes.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>The service provides information 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 are well informed about the Code of Rights. Monthly resident meetings provide the opportunity to raise concerns. An annual residents/relatives survey is completed. Staff receive training about the Code, which was last completed in June 2018.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with</p>	<p>FA</p>	<p>Staff interviewed could 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</p>

respect and receive services in a manner that has regard for their dignity, privacy, and independence.		can choose to engage in activities and access community resources. Staff attend education and training on abuse and neglect.
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	Summerset Mountain View 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. There was one resident who identified as Māori at the time of the audit. The resident's file was reviewed and included Māori cultures and preferences. Links are established with local iwi (Tui Ora) and other community representative groups. Cultural needs are addressed in the care plan. Staff interviewed could describe how they can ensure they meet the cultural needs of Māori.
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	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.
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	Staff job descriptions include responsibilities and staff sign a copy on employment. 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, clinical nurse leader and RNs confirmed an awareness of professional boundaries.
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	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 leader. 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

		<p>as other external aged care providers.</p> <p>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 Mountain View that adhere to the Health &amp; 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. The service has been working towards strong teamwork approach, encouraging by positive leadership and regular team building events.</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 and fifteen incident forms sampled confirmed this. Resident/relative meetings are held monthly. The village manager and the care centre manager have an open-door policy. 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>	FA	<p>The service provides care for up to 72 residents at hospital (geriatric and medical services) and rest home level care. There are 52 dual-purpose beds in the care centre on the first floor and 20 serviced apartments on the ground floor, certified to provide rest home level care. On the day of the audit there were 57 residents in total, 39 residents at rest home level (nine rest home level residents in the serviced apartments) and 18 hospital level residents, including one hospital resident on an ACC funded (under the age of 65) contract and one resident on a palliative care contract. All other residents are under the aged related residential care (ARRC) contract.</p> <p>Summerset group has a well-established organisational structure. Each of the Summerset facilities throughout New Zealand is supported by this structure. The Summerset group has a suite of policies and procedures, which will guide staff in the provision of care and services. The Summerset Group Limited Board of Directors have overall financial and governance responsibility and there is a company strategic business plan in place. Summerset Mountain View has a site-specific 2018 business plan and goals that are developed in consultation with the village manager, care centre manager and regional operations manager. There is a full evaluation completed at the end of the year.</p> <p>The village manager has been in the current role at Summerset for four years. The village manager is</p>

		<p>supported by a care centre manager. The care centre manager has been in the position for two years. The care centre manager is a RN who has experience in district nursing and palliative care. The care centre manager is supported by the clinical nurse leader who has been in the role for eight months. Management are supported by a regional operations manager and regional quality manager (who was present during the audit).</p> <p>Village managers and care centre managers attend annual organisational forums and regional forums over two days. There is a regional operations manager who is available to support the facility and staff. The village manager and care centre manager have attended at least eight hours of leadership professional development relevant to the role.</p>
<p><b>Standard 1.2.2: Service Management</b></p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>During a temporary absence, the care centre manager will cover the village manager's role. The regional quality manager provides 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><b>Standard 1.2.3: Quality And Risk Management Systems</b></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 Mountain View 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 completes a 'best practice' sheet confirming completion of requirements. The best practice sheet reports (but is not limited to): meetings held, induction/orientation, audits, competencies and projects and is forwarded to head office as part of the ongoing monitoring programme. A resident satisfaction survey was completed in September 2017 with a high overall satisfaction rate of 98%. Corrective actions were implemented evidencing that any suggestions and concerns were addressed.</p> <p>There is a meeting schedule including (but not limited to) monthly quality improvement, monthly staff meetings that include discussion about clinical indicators (eg, incident trends, infection rates). Health and safety, infection control and restraint meetings occur monthly. The service is implementing an internal audit programme that includes aspects of clinical care. Issues arising from internal audits are</p>

		<p>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.</p> <p>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 property manager is the health and safety representative (interviewed). The service addresses health and safety by recording hazards and near misses into Sway, sharing of health and safety information and actively encourage staff input and feedback. Each month there is a health and safety focus topic and staff are provided with resources and education about the topic.</p> <p>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.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Incident and accident data has been collected and analysed. Fifteen resident related incident reports for July 2018 were reviewed. All reports and corresponding resident files reviewed evidence that appropriate clinical care has been provided following an incident. Neurological observations are completed if there is a suspected injury to the head. The incident reporting policy includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Data is linked to the organisation's benchmarking programme and used for comparative purposes.</p> <p>Discussions with the management team confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been two section 31 notifications completed since the last audit for two pressure injuries, an unstageable pressure injury in June 2018 and a stage three pressure injury in January 2018.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management</p>	<p>FA</p>	<p>There are human resources policies to support recruitment practices. A list of practising certificates is maintained. Seven staff files (one care centre manager, one RN, one clinical nurse leader, one diversional therapist and three caregivers) were reviewed, and all had relevant documentation relating to employment. All files reviewed included annual performance appraisals for staff who had been</p>

<p>processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>employed for longer than one year. A register of RN practising certificates is maintained. Practising certificates for other health practitioners are retained to provide evidence of registration. 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.</p> <p>Staff interviewed could 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'. The plan is being implemented. Caregivers are completing A competency programme is in place with different requirements according to work type (eg, caregivers, RN and household staff). Core competencies are completed, and a record of completion is maintained on staff files as well as being scanned into 'Sway'. Three of the seven RNs are interRAI trained, including the care centre manager and clinical nurse leader. Staff interviewed were aware of the requirement to complete competency training. Caregivers complete an aged care programme.</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 village manager and care centre manager work 40 hours per week Monday to Friday and are available on call for any emergency issues or clinical support. The clinical nurse leader works full time Monday to Friday. Caregivers interviewed, confirmed that staff are replaced when off sick. A staff availability list ensures that staff sickness and vacant shifts are covered.</p> <p>In the care centre there were 48 residents in total (30 rest home and 18 hospital residents), there are two RNs on duty on the morning and afternoon shifts and one on the night shift. They are supported by seven caregivers on morning shifts (three long and four short shifts), six on the afternoon shifts (three long and three short shifts) and two on the night shifts (full shift).</p> <p>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 nine rest home residents. Staff carry pagers that alert them to call bells and walkie talkies so they can communicate effectively.</p> <p>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.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded,</p>	<p>FA</p>	<p>The resident files sampled 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. Other residents or members of the public cannot view sensitive resident information. Resident files are protected from unauthorised access by being held in a locked office. Care plans and notes were</p>

current, confidential, and accessible when required.		legible and where necessary, signed (and dated) by a RN. There is an allied health section that contained GP, allied health professionals and specialists' notes 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	There are policies and procedures to safely guide service provision and entry to services including an admission policy. The service has an information pack available for residents/families at entry. The admission agreements reviewed met the requirements of the ARRC agreement. Exclusions from the service are included in the admission agreement. All seven admission agreements (for long-term residents) sighted were signed and dated. One admission agreement is currently with the resident's solicitor.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Policy describes guidelines for death, discharge, transfer, documentation and follow up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities, and communication with 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 policies and procedures in place for all aspects of medication management, including self-administration. There was one resident self-administering on the day of audit. All policies and procedures had been adhered to. There were no standing orders. There were no vaccines stored on site. The facility uses an electronic and robotic pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. Registered nurses and senior medication competent caregivers administer medications.  All staff have up-to-date medication competencies and there has been medication education this year. Registered nurses have syringe driver training completed by the hospice. The medication fridge temperature is checked weekly. Eye drops are dated once opened. Staff sign for the administration of medications electronically. Sixteen medication charts were reviewed. Medications are reviewed at least three monthly by the GP. There was photo identification and allergy status recorded. 'As required' medications had indications for use prescribed.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management	FA	The facility uses a contracted company for food service. There is one kitchen coordinator, two cooks and three kitchenhands who cover the week between them. All have current food safety certificates. The kitchen coordinator oversees the procurement of the food and management of the kitchen. There



<p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>is a well-equipped kitchen and all meals are cooked on-site. Meals are taken to the dining rooms in hot boxes, then transferred into bain maries and served directly from these. Meals going to rooms on trays have covers to keep the food warm. Special equipment such as lipped plates are available. On the day of audit meals were observed to be hot and well-presented and residents stated that they were enjoying their meal. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures were monitored and recorded weekly.</p> <p>Food temperatures are checked, and these were all within safe limits. The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes were noted in a folder. The kitchen manager stated that residents could ask for snacks as desired. The eight-weekly menu cycle is approved by a dietitian. All residents and family members interviewed were satisfied with the meals. Residents have the opportunity to feedback on the service through resident meetings and surveys. Management liaise regularly with the kitchen coordinator to monitor feedback and identify any areas for improvement. The food control plan has been submitted, however this has not yet been verified by a site visit.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>The service records the reason for declining service entry to potential residents should this occur and communicates this to potential residents/family. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. InterRAI assessments had been completed for all long-term residents whose files were sampled. Overall the goals were identified through the assessment process and linked to care plan interventions. Other assessment tools in use included (but are not limited to) falls risk, pressure injury risk, pain and depression.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans</p>	<p>FA</p>	<p>Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans are resident-centred. Interventions documented support needs and provide detail to guide care.</p>

<p>are consumer focused, integrated, and promote continuity of service delivery.</p>		<p>Short-term care plans are in use for changes in health status. Residents and relatives interviewed, stated that they were involved in the care planning process. There was evidence of service integration with documented input from a range of specialist care professionals including the hospice nurse, wound care nurse and mental healthcare team for older people. The care staff interviewed advised that the care plans were easy to follow.</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>	<p>FA</p>	<p>When a resident's condition changes the RN initiates a GP consultation. Staff stated that they notify family members about any changes in their relative's health status and family interviewed confirmed this. All care plans sampled had interventions documented to meet the needs of the resident. Care plans have been updated as residents' needs changed. Resident falls are reported on accident forms and written in the progress notes. Neurological observations are completed for unwitnessed falls or falls where residents hit their heads. Care staff interviewed stated there are adequate clinical supplies and equipment provided including continence and wound care supplies.</p> <p>Wound assessment, wound management and evaluation forms are in place for all wounds. Wound monitoring occurs as planned. There are currently six wounds being treated. One chronic wound has had input from the GP and wound care nurse specialist. One lesion has been surgically removed by a specialist. There are currently three pressure injuries. Two are stage two and one is a non-facility acquired unstageable. The unstageable has had input from the GP and wound nurse and there are photos of the wound's progress. A Section 31 was completed. Monitoring forms are in use as applicable such as weight, vital signs and wounds. Behaviour charts are available for any residents that exhibit challenging behaviours.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>There is one diversional therapist (DT) who works 30 hours a week. The facility is currently recruiting for an activities assistant to assist her. On the days of audit, residents were observed doing exercises, playing bingo, singing and going for walks outside. On the days the DT is not at work she leaves out activities for residents to do with caregiver/volunteer assistance. There is a weekly programme in large print on noticeboards and residents also have a copy in their rooms. Residents have the choice of a variety of activities in which to participate and every effort is made to ensure activities are meaningful and tailored to residents' needs. These include exercises, games, quizzes, music and walks outside.</p> <p>Those residents who prefer to stay in their room or who need individual attention have one-on-one visits to check if there is anything they need and to have a chat. There is an interdenominational church service every Sunday afternoon and a Catholic deacon comes in to give communion. An Anglican vicar also holds monthly reflections. There are van outings one to two times a week. The DT</p>

		<p>has a first aid certificate. There are regular entertainers who visit the facility. Special events like birthdays, Easter, Father's Day, Anzac Day and the Melbourne Cup are celebrated. There is pet therapy fortnightly and there are cats in the village who like to visit. There is community input from pre-schools and schools, Kapa Haka groups, the RSA and the village residents.</p> <p>Residents go out in the van and some like to visit the RSA. Residents have an activity assessment completed over the first few weeks following admission that describes the residents past hobbies and present interests, career and family. Resident files reviewed identified that the activity plan is based on this assessment. Activity plans are evaluated at least six monthly at the same time as the review of the long-term care plan. Resident meetings are held monthly. There has been a recent quality initiative where the DT introduced an audio book/music chair in the serviced apartment lounge for all residents to use. This provides an opportunity for sight impaired residents to enjoy the pleasure of a book/music CDs.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Six care plans reviewed had been evaluated by the RNs six monthly or when changes to care occurs. The other two care plans were for residents who were relatively new admissions. Short-term care plans for short-term needs are evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. Activities plans are in place for each of the residents and these are also evaluated six monthly. The multidisciplinary review involves the RN, GP and resident/family if they wish to attend. There are three monthly reviews by the GP for all residents. Family members interviewed confirmed that they are informed of any changes to the care plan.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where residents had been referred to the wound care nurse specialist and mental health services for older people. Discussion with the RN identified that the service has access to a wide range of support either through the GP, specialists and allied health services as required.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service</p>	FA	<p>There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas. Safety data sheets and product sheets are available. Sharps containers are available and meet the hazardous substances regulations for</p>

<p>providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>		<p>containers. The hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff. A spills kit is available.</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>	<p>FA</p>	<p>The building holds a current warrant of fitness which expires 6 September 2018. The village manager confirmed that checks have been completed for this to be renewed by the expiry date. There is a property manager and a maintenance man who both work on-site 40 hours a week. Contractors are available when required. There is also a fulltime gardener who has a part-time assistant. Electrical equipment has been tested and tagged. The hoist and scales are checked annually. Hot water temperatures have been monitored randomly in resident areas and were within the acceptable range.</p> <p>The communal lounges and hallways are carpeted. The corridors are wide and have safety rails, and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained. There is an upstairs outdoor balcony area as well. All outdoor areas have seating and shade. There is safe access to all communal areas. Caregivers interviewed stated they have adequate equipment to safely deliver care for rest home and hospital level of care residents.</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>	<p>FA</p>	<p>There are six rooms which shared communal showers and toilets. All other rooms have full ensembles. Fixtures, fittings and flooring are appropriate. Toilet/shower facilities are easy to clean. There is ample space in toilet and shower areas to accommodate shower chairs and hoists if appropriate. There are privacy signs on all shower/toilet doors.</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>	<p>FA</p>	<p>There are 52 rooms in the care centre. At present one of the larger rooms is being occupied by a married couple. This room was verified as suitable as a double-room for a married couple. There were two call bells available. There are nine rest home residents in serviced apartments. There is sufficient space in all areas to allow care to be provided and for the safe use of mobility equipment. Staff interviewed reported that they have adequate space to provide care to residents. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.</p>

<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>There are large and small communal areas. Activities occur in the larger areas and the smaller areas are spaces where residents who prefer quieter activities or visitors may sit. There are two spacious dining rooms. There is a café, exercise gym and hairdressing salon.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>All laundry is done on site. The laundry is divided into a “dirty” and “clean” area. There is a laundry and cleaning manual, and safety datasheets. Personal protective equipment is available. Cleaning and laundry services are monitored through the internal auditing system. The cleaner’s equipment was attended at all times or locked away. All chemicals on the cleaner’s trolley were labelled. There are two sluice rooms for the disposal of soiled water or waste and the sluicing of soiled linen if required. The sluice room and the laundry are kept closed when not in use.</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>	FA	<p>There is an emergency and civil defence plan in place to guide staff in managing emergencies and disasters. A quality initiative was introduced in June 2018 to have a site-specific emergency management folder in each of the fire cell zones within the building. The purpose of the site-specific emergency management folder is to simplify the understanding for staff on duty of the area they are allocated in an emergency. Staff emergency and disaster management training is provided to staff. There is a first aid trained staff member on every shift and accompanying residents on outings. There is an approved fire evacuation plan dated 31 August 2017.</p> <p>Fire safety training has been provided. Fire evacuation drills have been conducted six monthly with the last fire drill occurring on 3 April 2018. Civil defence, first aid and pandemic/outbreak supplies are available and are checked regularly. Sufficient water (ceiling tanks) is stored for emergency use and alternative heating and cooking facilities (two BBQs) are available. Smoke alarms, sprinkler system and exit signs are in place. The facility is secured at night. There are call bells in all resident rooms, toilet/shower areas and communal areas. Visitors and contractors sign in at reception when visiting. Visitors and contractors sign in at reception when visiting.</p>
<p>Standard 1.4.8: Natural Light,</p>	FA	<p>All bedrooms and apartments and communal areas have ample natural light and ventilation. All</p>

<p>Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>		<p>heating is electrical. Staff and residents interviewed stated that this is effective. There are two outdoor areas where residents/staff smoke. All other areas are smoke free.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>There is an infection control coordinator (ICC) who has responsibility for infection control across the facility. Responsibility for infection control is described in the ICC job description. There is an infection control committee who assists the ICC as required. This committee has a representative from each area. The infection control coordinator oversees infection control for the facility and is responsible for the collation of monthly infection events and reports. The infection control programme is reviewed annually. Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility. Residents are offered the annual influenza vaccine. There have been no outbreaks since the last audit.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The infection control coordinator has been in the role for a year. She has completed the Somerset infection control programme and the ministry of health's online infection control education programme. She is currently liaising with the DHB to attend regional infection control meetings. The care centre manager has also completed the Somerset infection control programme. There is access to infection control expertise within the DHB, wound nurse specialist, public health, and laboratory. The GP monitors the use of antibiotics.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are</p>	<p>FA</p>	<p>The infection control policies include a range of standards and guidelines including defined roles and responsibilities for the prevention of infection; and training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. The policies have been developed by a Somerset infection control specialist.</p>

practical, safe, and appropriate/suitable for the type of service provided.		
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	The ICC is responsible for coordinating/providing education and training to staff. Training on infection control is included in the orientation programme. The ICC provides at least three study days annually and keeps staff updated with information on noticeboards. Resident education occurs as part of providing daily cares and as applicable at resident meetings.
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Infection control data including trends, is discussed at infection control and quality meetings. Meeting minutes including graphs are available to staff on noticeboards. Trends are identified and analysed, and preventative measures put in place. The facility is looking to benchmark with similar Summerset facilities. There is also a quality initiative in place with the aim of reducing respiratory infections. This is currently ongoing. Systems in place are appropriate to the size and complexity of the facility.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	There are policies around restraints and enablers. The service currently has one resident assessed as requiring the use of restraint (bedrail) and one requiring an enabler (bedrail). The care plans are up to date and provide the basis of factual information in assessing the risks of safety and the need for restraint. Ongoing consultation with the resident and family/whānau is also identified. Residents voluntarily request and consent to enabler use. Staff receive training around restraint minimisation that includes annual competency assessments.
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this</p>	FA	A restraint approval process and a job description for the restraint coordinator are in place. The restraint coordinator role is delegated to the clinical nurse leader. All staff are required to attend restraint minimisation training annually.

process is made known to service providers and others.		
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>Only registered nursing staff can assess the need for restraint. Restraint assessments are based on information in the resident's care plan, discussions with the resident and family and observations by staff. A restraint assessment tool meets the requirements of the standard. The hospital level residents file where restraint was being used was reviewed. The file included a restraint assessment and consent form that was signed by the resident's family. The completed assessment considered those listed in 2.2.2.1 (a) - (h).</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>A restraint register is in place. The register identifies the residents that are using a restraint, and the type(s) of restraint used. The restraint assessment identified that restraint is being used only as a last resort. The restraint assessment and ongoing evaluation of restraint use process includes reviewing the frequency of monitoring residents while on restraint. Monitoring forms are completed when the restraint is put on and when it is taken off.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Restraint use is reviewed monthly during the quality improvement meetings. The review process includes discussing whether continued use of restraint is indicated.</p>
<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>	FA	<p>The restraint programme, including reviewing policies and procedures and staff education is evaluated annually by the national quality manager and the national education manager.</p>



## Specific results for criterion where corrective actions are required

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

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

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

No data to display
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display
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End of the report.