

Summerset Care Limited - Summerset by the Ranges

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 by the Ranges
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 4 March 2020 End date: 5 March 2020
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	47

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Summerset by the Ranges provides rest home, hospital and dementia level care for up to 51 residents in the care centre. On the day of the audit there were 47 residents.

The service is managed by a village manager/registered nurse who has been in the role one year and was previously the care centre manager. She is supported by a care centre manager who has been in the role nine months and has a background in community rehabilitation.

The residents, relatives and general practitioner interviewed spoke positively about the care and support provided at Summerset by the Ranges.

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, general practitioner and allied health professionals.

There is an area for improvement around neurological observations and restraint monitoring.

The service is commended for achieving two continued improvement ratings around good practice and recognition of Māori values and beliefs.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		All standards applicable to this service fully attained with some standards exceeded.
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Summerset by the Ranges 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 the community.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Summerset by the Ranges has a well-established quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to a number of meetings including monthly quality improvement meetings, infection control and health and safety. Annual surveys and 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.		Some standards applicable to this service partially attained and of low risk.
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The service has assessment processes and residents' needs are assessed prior to entry. There is a well-developed information pack available for residents and families/whānau at entry. Assessments, resident centred care plans and evaluations were completed by the registered nurses within the required timeframes. Risk assessment tools and monitoring forms were available and implemented.

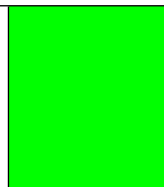
A diversional therapist and activity coordinator plan and implement an activity programme across the care centre and in the dementia unit. The activities meet the individual recreational needs and preferences of the consumer groups. There are outings into the community and visiting entertainers.

There is a robust medication system 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 managed and undertaken in-house. Resident's individual dietary needs were identified and accommodated. Staff have attended food safety and hygiene training. Additional snacks were available after hours.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.

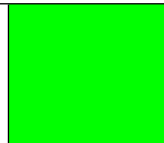


Standards applicable to this service fully attained.

There were documented processes for the management of waste and hazardous substances in place and incidents are reported in a timely manner. Chemicals were stored safely throughout the facility. The building has a current warrant of fitness. Resident bedrooms are spacious and personalised with access to ensuites. There was sufficient space to allow the movement of residents around the facility using mobility aids or lazy-boy chairs. The hallways and communal areas are spacious and 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 a first aid trained staff member on duty at all times. Housekeeping staff maintain a clean and tidy environment. All laundry and linen is completed on site. There is plenty of natural light in all rooms and the environment is comfortable with adequate ventilation and heating.

Restraint minimisation and safe practice

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

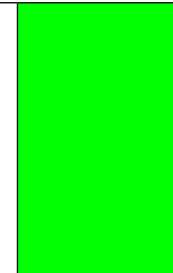


Standards applicable to this service fully attained.

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. The service has two restraints. Staff receive regular education and training on restraint minimisation.

Infection prevention and control

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



Standards applicable to this service fully attained.

The infection control programme is appropriate for the size and complexity of the service. The infection control coordinator (RN) is responsible for coordinating and providing education and training for staff. The infection control coordinator has completed online training. The infection control manual outlined the scope of the programme and included current policies and guidelines. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This included audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Somerset facilities.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	1	47	0	2	0	0	0
Criteria	2	97	0	2	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Discussions with nine care staff (two registered nurses [RN], five caregivers and one diversional therapist [DT] and one activity coordinator), confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Four residents (two hospital and two rest home) and three relatives (two hospital and one relative of a dementia care resident) were interviewed and confirmed the services being provided are in line with the Code. Observation during the audit confirmed this in practice. All staff complete education around consumer rights last in June 2019.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. Written general and specific consents were evident in the seven resident files reviewed, (three hospital (including one ACC), two rest home (including one respite) and two memory care residents (dementia level of care level). Caregivers and registered nurses interviewed confirmed consent is obtained when delivering cares. Resuscitation orders had been appropriately signed. The general practitioner (GP) had discussed resuscitation with families/EPOA where the resident was deemed incompetent to make a decision. The enduring power of attorney had been activated in the dementia resident files reviewed. Discussion with family members (one dementia care and two hospital) identified that the service actively involves them in decisions that affect their relative's lives. Seven admission agreements sighted were signed.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Residents are provided with a copy of the Code of Rights and access to advocacy services 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. A member of Age Concern visits three monthly and is available for discussions with residents as desired.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents and relatives interviewed confirmed open visiting. 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 cafes. Interview with staff, residents and relatives informed residents are supported and encouraged to remain involved in the community and external groups. There are links with Age Concern and Alzheimer's Society. 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>	FA	<p>The organisational complaints policy states that the village manager has overall responsibility for ensuring all complaints (verbal or written) are fully documented, had been investigated and resolved. There is an on-line complaint register that includes relevant information regarding each complaint including investigation notes, letters of acknowledgment and offers of advocacy if the complainant is not satisfied with the outcome. There have been five care centre complaints for 2019 and none to date for 2020. Timeframes for acknowledging complaints met the HDC requirements. All complaints had been resolved to the satisfaction of the complainant.</p> <p>Complaints and concerns are discussed at the relevant facility meeting. A complaints procedure is provided to residents within the information pack at entry. Complaint and compliments forms are available for residents/relatives at the care centre reception.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>The service provides information in the welcome pack 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. The Code of Rights are displayed at the main entrance to the care centre. Monthly resident meetings and the annual residents/relatives survey is completed and provides an opportunity to raise concerns.</p>

<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>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. Resident files include cultural and spiritual values and chosen networks and contacts. Residents and relatives interviewed reported that residents are able to choose to engage in activities, access community resources and are supported to attend church services. Staff were observed knocking on resident doors before entering the room.</p> <p>There is an elder abuse and neglect policy. Staff receive education and training on abuse and neglect as part of the training calendar.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>Summerset has a Māori health plan 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. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. There was one Māori resident on the day of audit. The service has a Māori Cultural Advisor who is the activity coordinator in the village. The Māori Cultural Advisor has strong links with local iwi, marae, local kaumātua and the DHB Māori Health Unit (representative of four iwi) who have been active in reviewing the Māori health model which aligns with Summerset by the Ranges Māori health plan.</p> <p>Staff interviewed were able to describe how they can ensure they meet the cultural needs of residents identifying as Māori. Treaty of Waitangi and cultural safety education is provided.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>An initial care planning meeting is carried out where the resident and/or family/whānau as appropriate/able are invited to be involved. Individual beliefs or values are further discussed and incorporated into the electronic care plan. Six monthly multi-disciplinary team meetings occur to assess if the resident's individual needs are being met. Family are invited to attend. Discussion with relatives confirmed values and beliefs are considered. Residents interviewed confirmed that staff take into account their culture and values.</p>
<p>Standard 1.1.7: Discrimination</p>	FA	<p>Staff job descriptions include responsibilities and scope of practice. Staff sign a copy on employment. Staff meetings occur monthly and include discussions on professional boundaries and concerns as they</p>

<p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>		<p>arise. Staff sign the professional boundaries policy on employment. Interviews with the care centre manager, clinical nurse leader and registered nurses confirmed an awareness of professional boundaries. Caregivers interviewed were knowledgeable around the scope of their role and responsibilities.</p>
<p>Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.</p>	<p>CI</p>	<p>All Summerset facilities have a master copy of policies which have been developed in line with current accepted best practice and are reviewed regularly. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff. In 2018, all staff attended palliative care education as part of the SEQUAL provided by the hospice nurse specialist. The service has continued to strengthen their focus around end of life care and have implemented the Te Ara Whakapiri pathway in consultation with the palliative care nurse specialist. The service has evidenced good practice around end of life care.</p> <p>There is a culture of ongoing staff development with an in-service programme being implemented. Senior caregivers have been selected as caregiver coaches who support newly appointed caregivers during the initial orientation and continue to provide ongoing support. Caregivers, once orientation has been completed hold level two Careerforce unit standards. The caregivers and RNs have the opportunity to attend external study days as offered. Registered nurses are linked to the DHB professional development recognition programme (PDRP) with two RNs achieving competent level. The CNL has achieved PDRP proficient level and is the wound champion for the service. All eight RNs attended pressure injury prevention and wound care April 2019. Caregivers interviewed could describe pressure injury prevention strategies and reporting requirements. There have been no facility-acquired pressure injuries since February 2019 to date.</p> <p>Residents and relatives interviewed spoke very positively about the care and support provided. Staff interviewed felt supported by the village manager, care centre manager and clinical nurse leader.</p>
<p>Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>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 resident's health status and incidents/accidents as evidenced in 14 accident/incidents reviewed on the electronic register. Resident/relative meetings are held monthly. Meeting minutes evidenced discussion around all areas of services provided. The results of resident/relative surveys have been communicated to residents/relatives. Every third month there is a resident meeting with an advocate from Age Concern. 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).</p>

<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>On the day of the audit, there were 30 residents in the dual-purpose beds with 13 at rest home level (including one respite care) and 17 hospital level residents (including one resident funded by ACC). There is a 20-bed dementia care unit (10 residential beds including one designated respite care bed and 10 apartments). On the day of audit there were 17 residents (10 in residential beds and seven in apartments). There was a total of 47 residents in the facility.</p> <p>The Summerset Group Limited Board of Directors have overall financial and governance responsibility and there is a company strategic business plan in place. Summerset by the Ranges has a site-specific business plan and quality goals which is linked to the business plan including a focus on providing a dementia friendly village, reducing urinary tract infections UTIs by 50% and reducing falls. The 2019 goals have been reviewed quarterly and the 2020 goals developed in consultation with the regional operations manager, regional quality manager, village manager and care centre manager. The management team are supported by a regional operations manager and a regional quality manager (present on the days of audit) who visit the facility monthly. There are also regular “zoom” meetings and site visits.</p> <p>The village manager has been in the current role since March 2019 and was previously the care centre manager at the site. The care centre manager was appointed nine months ago. She has a background in community rehabilitation and medical acute nursing. HealthCERT and the DHB were notified of both appointments.</p> <p>The village manager has attended a two-day Summerset conference for village managers, RVA conference, and “leading the walk” (18 hours) course for managers. The care centre manager completed a specific manager orientation and has attended the aged care conference in 2019.</p> <p>The care centre manager is supported by a clinical nurse leader who has proficient level of the PDRP and has been an RN at the facility since 2014.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>During a temporary absence, the care centre manager will cover the village manager’s role. The regional quality manager provides oversight and support. The CNL provides cover for the care centre manager. A relieving manager covers if the leave is longer than two weeks. The audit confirmed the service has operational management strategies and a quality improvement programme to minimise risk of unwanted events.</p>

<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>Summerset by the Ranges 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 from head office. The content of policy and procedures are detailed to allow effective implementation by staff. Staff are required to read and sign for new/reviewed policies. There is a master folder of current policies available to 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. The village manager and care centre manager complete monthly reports confirming completion of requirements. There is a meeting schedule including fortnightly management meetings, monthly quality improvement meetings, full staff meetings, caregiver meetings and registered nurse meetings. The infection control committee and health and safety committee meet monthly. Quality improvement, health and safety and infection control meeting minutes are available to all staff. Minutes evidenced discussion around quality data including infections, accidents/incidents, hazards, audit outcomes, concerns/complaints, medications, wounds and restraint as relevant for the staff group. Trends and analysis for infections and accidents/incidents are displayed for staff.</p> <p>There are monthly accident/incident benchmarking reports completed by the care centre manager that break down the data collected across the rest home, hospital and dementia care residents. Infection control is also included as part of benchmarking across the organisation. The regional quality manager analyses data collected via the monthly reports and corrective actions are required based on benchmarking outcomes.</p> <p>The service is implementing an internal audit programme that includes environmental, infection control, health and safety, consumer rights and aspects of clinical care. Issues arising from internal audits are developed into corrective action plans and signed off when completed. Audit outcomes are discussed at quality improvement meetings.</p> <p>Annual resident/relative surveys are completed. The 2019 survey was 96% overall satisfaction for Summerset by the Ranges and the Summerset overall satisfaction rate was 96.4%. There were slight improvements for meals, activities and personal care. Participants were thanked with personal letters and informed of the survey results.</p> <p>There is a health and safety and risk management programme in place including policies to guide practice that is generated from the national health and safety manager at head office. The village manager is the health and safety officer. There is a health and safety committee with representatives across the services. The health and safety committee comprise of representatives across the services. Three health and safety representatives and the village manager have completed an external health and safety course. Committee meetings are held monthly. There were meeting minutes, a health and safety newsletter,</p>
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		<p>hazard register and the golden rule for the month displayed on the health and safety noticeboard. Hazards are reported through the RMSS with an alert to managers. Health and safety induction is completed as part of the orientation programme. The service has a return to work programme following staff injury.</p> <p>Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls. Fall prevention strategies are documented in individual care plans and include the use of sensor mats, hip protectors and physiotherapist input.</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>	FA	<p>Incident and accident data have been collected and analysed. Fourteen resident related incident reports for January 2020 were reviewed including skin tears, challenging behaviour, witnessed and unwitnessed falls. All reports and electronic resident accident/incident reports reviewed, evidenced that appropriate clinical care has been provided following an incident, however neurological observations had not been completed as per protocol for unwitnessed falls (link 1.3.6.1). All incidents/accidents evidenced the relative had been notified. The regional quality manager is alerted automatically through the RMSS system of any high-level accident/incidents (resident, staff and environmental).</p> <p>The incident reporting policy includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Data is linked to the organisation's benchmarking programme and used for comparative purposes.</p> <p>Discussions with the village manager and care centre manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been no Section 31 notifications.</p> <p>There have been two outbreaks, with one in May 2019 (norovirus) and one in July 2019 (influenza A). Public Health was notified for each outbreak.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are human resources policies to support recruitment practices. A register of practising certificates is maintained for registered nurse, GPs and allied health professionals involved with the service. Eight staff files (one clinical nurse leader, one RN, three caregivers, one activity coordinator, one chef manager and one property manager) were reviewed. All files contained the required recruitment and employment documents. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. There are senior caregiver coaches who support staff through their orientation process. Annual performance appraisals had been completed at three weeks post-employment and annually thereafter.</p> <p>There is an annual education plan that is outlined on the 'clinical audit, training and compliance calendar'.</p>

		<p>The 2019 training plan has been completed and the 2020 training schedule has commenced. There are repeat sessions of same training offered to accommodate staff on all shifts. For staff unable to attend training they are required to read and sign the education content. Records of individual attendance is maintained. 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. The physiotherapist provides safe manual handling training.</p> <p>Staff have the opportunity to attend external education such as DHB study days and palliative care at the hospice. The village manager and the diversional therapist are Careerforce assessors. There are seven RNs including two casual RNs. Five RNs and one casual RN and the CNL have completed interRAI training.</p> <p>There are 12 caregivers employed in the dementia care unit. Ten have completed the dementia unit standards and one caregiver is currently progressing through the units. One caregiver has been employed recently and to commence training.</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 (registered nurse) works full-time (Monday to Friday) and is available on call for any operational issues or clinical support. The care centre manager and clinical nurse leader (based in the dementia care unit) work Monday to Friday and share the on-call. There is one RN on the morning, afternoon and night shift in the care centre. The RN on duty oversees the dementia care unit during afternoon and night shifts³. There is an RN on duty in the dementia care unit Saturday and Sunday from 8 am – 12.30 pm.</p> <p>Care Centre: (13 rest home and 17 hospital level residents) - There are four caregivers on the full morning shifts and one caregiver until 1.30pm. On afternoon shift there are two caregivers on the full shift, one caregiver on the short shift finishing at 9.30 pm and one caregiver finishing at 7 pm. There are two caregivers on night shift. One caregiver with a first aid certificate is allocated on each shift to attend emergency calls in the village.</p> <p>Dementia care unit: On mornings there is one caregiver on the full shift and one caregiver until 1.30 pm. There are two caregivers on the full afternoon shift and night shift.</p> <p>The diversional therapist and recreational therapist cover a seven-day roster for the dementia care unit and Tuesday to Saturday in the care centre.</p> <p>There are designated laundry and housekeeping staff for the care centre and serviced apartments.</p> <p>Caregivers interviewed confirmed that staff are replaced. The roster reviewed confirmed that staff are replaced with Summerset existing or casual staff. Relatives and residents confirmed there were sufficient staff on duty.</p>

<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident files were appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Electronic resident files are password protected from unauthorised access. Individual resident files demonstrated service integration.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>All residents have a needs assessment completed prior to entry that identifies the level of care required. The care centre manager screens all potential enquiries to ensure the service can meet the required level of care and specific needs of the resident.</p> <p>Four residents (two rest home and two hospital) 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.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>There is an exit, discharge and transfer policy that describes guidelines for death, discharge, transfer, documentation and follow-up. All relevant information is documented and communicated to the receiving health provider or service. Follow-up occurs to check that the resident is settled or, in the case of death, communication with the family is made.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>The service medication management system follows recognised standards and guidelines for safe medicine management practice in accordance with the Medicines Care Guide for Residential Aged Care. RNs are responsible for the administration of medications in the rest home, hospital wings and the dementia care unit. Senior caregivers' complete competencies for the checking and witnessing of medications as required. Medication competencies and education has been completed annually. All medications delivered were evidenced to be checked on delivery with any discrepancies fed back to the supplying pharmacy. The medication room temperature is taken and recorded daily – consistently under 25 degrees. The two fridges (one for samples, one for medications) have their temperatures taken and recorded daily. The service uses an electronic medication system. Standing orders are not used. There were two residents self-medicating on the day of audit (inhalers only). Both had been deemed competent and this was reviewed at each medication review. Medication administration was observed to be fully</p>

		<p>compliant with policy and procedure.</p> <p>Fourteen resident medication charts on the electronic medication system were reviewed (six hospital, four rest home and four dementia). The charts had photograph identification and allergy status recorded. The prescribing of regular and 'as required' medications meets legislative requirements. The time and date of 'as required' medications was recorded.</p> <p>All 12 of 14 medication charts reviewed identified that the GP had reviewed the medication chart at least three monthly (one resident had been at the facility less than a week and the other was respite care).</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>There is an in-house food service. There is a four season, four weekly, rotating menu approved by the dietitian. The chef manager is supported by a team of kitchenhands. Resident likes/dislikes and preferences are known and accommodated with alternative meal options. The kitchen is adjacent to the dining room in the care centre (rest home/hospital) and food is transported to the dementia care unit in a hot box where it is served from a kitchen/servery area to residents in the adjacent dining room. Special diets include low residue, pureed meals as assessed and diabetic desserts. The cook receives a dietary profile for each resident. The service has initiated a quality project for the use of pure foods pureed options for residents on a soft diet.</p> <p>The fridge, freezer and dishwasher have daily temperatures recorded. End cooked food temperatures are recorded twice daily. All foods are stored correctly and date labelled. Cleaning schedules are maintained. Chemicals are stored safely within the kitchen. Staff were observed wearing correct personal protective clothing when entering the kitchen. The chemical provider completes a functional test on the dishwasher monthly.</p> <p>Staff working in the kitchen have food handling certificates and chemical safety training. Snacks are available for all residents 24 hours per day. Residents and relatives spoke well of the food service. Ministry for Primary Industries approved Food Safety Plan is due for renewal 27 June 2020.</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,</p>	<p>FA</p>	<p>The reason for declining service entry to potential residents should this occur is communicated to the potential resident or family/whānau and they are referred to the original referral agent for further information.</p>

where appropriate.		
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>The initial support plan is developed with information from the initial assessment. Clinical risk assessments are completed on admission where applicable and reviewed six monthly as part of the interRAI assessment. Risk assessment tools are used to identify the required needs and interventions required to meet resident goals. The interRAI assessment was completed within 21 days for new admissions. All residents have an interRAI assessment in place which informs the care plan (the respite resident had a community interRAI).</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	PA Low	<p>Resident centred care plans describe the individual support and interventions required to meet the resident's goals, however there were no documented interventions for two insulin dependent residents. The care plans reflect the outcomes of risk assessment tools. Care plans demonstrate service integration and include input from allied health practitioners. Short-term care plans were in use for changes in health status.</p> <p>There is documented evidence of resident/family/whānau involvement in the care planning process. Residents/relatives interviewed confirmed they participate in the care planning process.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	PA Low	<p>When a resident's condition changes; the RN initiates a review and if required a GP or nurse specialist consultation. Relatives interviewed, stated their relatives' 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.</p> <p>Adequate dressing supplies were sighted. An initial wound assessment with ongoing wound evaluations and treatment plan was in place for the one wound on site (a basal cell carcinoma). There were no other wounds including skin tears. Wounds are re-assessed at least monthly. Evaluation comments were documented at each dressing change. There were no pressure injuries on the day of audit. The RNs and CNL confirmed there is a wound nurse specialist available as required.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management and continence products identified for day use, night use, and other management. A continence nurse specialist is available as required. A senior care assistant has responsibility for the product assessments and supplies and liaising with the continence representative regarding staff support and training.</p> <p>There are a number of monitoring forms used to monitor residents progress including, behaviour, weight</p>

		and vital sign charts, neurological monitoring charts and food and fluid intake charts. However, enabler and restraint monitoring had not been completed as per the care plan and neurological observations had not been completed for unwitnessed falls.
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The service currently employs an activities officer (undertaking their diversional therapy qualifications) for 60 hours per fortnight (Tuesday to Saturday) to coordinate and deliver the integrated rest home and hospital programme. There is a qualified diversional therapist working 37 hours per week (Monday to Friday) in the dementia care unit. The DT attends regional DT workshops. The programme is five days a week from Monday to Saturday with care assistants being involved in weekend activities such as ensuring exercises and movies are initiated as scheduled.</p> <p>The programme is planned a month in advance and includes set activities with the flexibility to add other activities of interest or suggestions made by residents. Activities meet the recreational needs of all resident groups ensuring all residents have the opportunity for outings, shopping, library visits, inter-home visits. There are also opportunities to attend community groups/events including concerts, pantomimes and Alzheimer's Group. Residents are encouraged to maintain their former community links. Church services are held fortnightly for all denominations and Holy Communion. Weather permitting residents are taken for frequent walks in the attractive surrounding gardens. One-on-one contact is made with residents who are unable or choose not to participate in group activities.</p> <p>The service has a wheelchair van for outings along with a car. The DT has a current first aid certificate.</p> <p>Resident/relative meetings provide an opportunity for feedback on the programme and there was evidence this is acted upon. Newsletters are sent out to families informing them of upcoming events and are invited to attend and a programme of activities is on the lounge wall in the memory care unit and a copy is given to each resident in the care centre.</p> <p>Activity assessments were sighted in six resident files and had been completed in consultation with the family on admission. The RH respite resident confirmed on interview they had been given a programme of what was on and welcomed to join in. The DT and activity coordinator are involved in the MDT reviews as evidenced in documentation sighted in resident files. Activity plans and care plans were reviewed at the same time. Residents and relatives expressed satisfaction with the activities programme.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely</p>	FA	<p>There is evidence of resident and family involvement in the review of resident-centred care plans. All initial care plans were evaluated by the registered nurses within three weeks of admission. Written evaluations were completed six monthly or earlier for resident health changes in five of seven files reviewed (one resident had not been at the service six months and the other resident was respite care).</p>

manner.		There is evidence of multidisciplinary (MDT) team involvement in the reviews including input from the GP and any allied health professionals involved in the residents' care. Families are invited to attend the MDT review and are sent a copy of the care plan if they are unable to attend. Short-term care plans sighted have been evaluated by the RN. The GP completes three monthly reviews.
<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	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.
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Safety data sheets were readily accessible for staff. Chemical bottles sighted have correct manufacturer labels. Chemicals were stored safely throughout the facility. The property manager is the approved handler for chemicals. Personal protective clothing was available for staff and seen to be worn by staff when carrying out their duties on the day of audit. Relevant staff have completed chemical safety training.
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	The building has two current building warrants of fitness that expire on 8 July 2020 (Care unit) and 20 July 2020 (dementia care unit). There is a full-time property manager who oversees the property and gardening team and is available on call for facility matters. Planned and reactive maintenance systems are in place and maintenance requests are generated through the electronic on-line system (property services requests). All electrical equipment has been tested and tagged. Clinical equipment has had functional checks/calibration annually. Hot water temperatures have been tested and recorded monthly with readings between 42-45 degrees Celsius. Corrective actions have been recorded for temperatures outside of the acceptable range. Preferred contractors for essential services are available 24/7. There

		<p>has been ongoing refurbishment with the painting and replacing of carpets in bedrooms.</p> <p>Corridors are wide in all areas to allow residents to pass each other safely. There is safe access to all communal areas and outdoor areas. There is outdoor seating and shade. The dementia care unit has an attractive secure outdoor area incorporating shaded seating areas, walking paths and gardens of interest. The external areas are well maintained.</p> <p>The caregivers and registered nurses (interviewed) stated they have all the equipment required to provide the care documented in the care plans.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>Visual inspection evidenced toilet and shower facilities are of an appropriate design to meet the needs of the residents. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. All bedrooms in the care centre have either a shared or single ensuite. In the dementia care unit, they are either ensuite or have a communal facility nearby. There are communal toilets located near the lounge/dining rooms. Communal toilet facilities have a system that indicates if it is engaged or vacant.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>There is adequate room to safely manoeuvre mobility aids and transferring equipment such as hoists in the resident bedrooms. The doors are wide enough for ambulance trolley access. Residents and families are encouraged to personalise their rooms as viewed on the day of audit.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Communal areas within the care facility include a large lounge and spacious dining area that can accommodate rest home and hospital level residents and where most activities take place. There are three smaller lounges where individual or small group activities occur such as reading, knitting and cards. The communal areas are easily accessible for residents. In the dementia care unit, there is a large lounge and dining area along with a smaller lounge that can also be used for dining if desired.</p>

<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>There are 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. Care staff complete laundry duties across the three shifts. The laundry has a dirty to clean workflow with an entry and exit door. There is dedicated housekeeping staff on seven days a week. Cleaning trolleys sighted were well equipped and are kept in designated locked cupboards when not in use. External (chemical provider) and internal audits monitor the effectiveness of laundry and cleaning processes.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>There are emergency and civil defence plans to guide staff in managing emergencies and disasters. Civil defence and emergency planning are included in the orientation and ongoing in the education plan and last competed in June 2019. Summerset by the Ranges has an approved fire evacuation plan approved 28 October 2016. Fire drills occur six monthly.</p> <p>There is civil defence equipment available and includes sufficient food, alternative cooking with barbeques and sufficient stored tank water and bottled water. There is an on-site generator. There is a first aid trained caregiver on duty at all times who responds to village callouts.</p> <p>Call bells were evident in residents' rooms, ensuites, communal toilets, dining and lounge areas. Care staff have pagers which receive all calls (from the care centre, serviced apartments and emergency calls from the dementia care unit. Walkie-talkies are used for communication on duty.</p> <p>The facility is secured at night with call bell access at the front doors. External sensor lighting is in place. There are external cameras at the main entrance, gates and back of the dementia care unit. The village is secure with main gates that are locked afterhours with access for village residents and emergency services.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>Visual inspection evidenced that the residents were provided with adequate natural light, safe ventilation and an environment that is maintained at a safe and comfortable temperature. The facility has underfloor heating, some heating panels and air conditioning units.</p>
<p>Standard 3.1: Infection control management</p>	FA	<p>The infection control programme is appropriate for the size and complexity of the service. There is an infection control responsibility policy that includes responsibilities for the infection control officer. The infection control officer (RN) has been in the role two months with a signed job description. She is being</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>supported by the village manager who previously held the role. The infection control programme is linked into the quality management system and reviewed annually in consultation with the infection control committee and the national infection control advisor at head office. There are monthly “zoom” meetings with all Summerset infection control coordinators which covers topical infection control matters, education and benchmarking results.</p> <p>There are notices at main entrances asking visitors not to visit if they are unwell. There is a community noticeboard in the entrance with infection control information. Influenza vaccines are offered to residents and staff. The infection control quality action plan for 2020 includes staff winter wellness and extending influenza vaccines to contractors involved in the service. Hand sanitisers are readily available throughout the facility. There is adequate personal protective equipment and outbreak kits readily available.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The infection control coordinator has completed an orientation to the role and on-line infection control courses. There is an infection control committee with representatives across all services. The committee meet monthly to discuss infection control matters including infection events, trends, analysis and corrective action plans. A report is forwarded to the quality improvement meeting.</p> <p>The infection control coordinator has access to an infection control nurse specialist at the DHB, laboratory, pharmacy, GPs, public health and expertise within the organisation.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>Policies and procedures are developed and reviewed at head office. Policies are available to all staff. They are notified of any new/reviewed policies and are required to read and sign for these.</p>

<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The infection control coordinator is responsible for coordinating and providing education and training to staff. The orientation package includes specific training around handwashing competencies, standard precautions and outbreak management. Ongoing training occurs annually as part of the training calendar set at head office. Staff have completed infection control competencies. Registered nurses have access to DHB Ko Awatea on-line learning for infection control.</p> <p>Resident education occurs as part of providing daily cares. Care plans can include ways to assist staff in ensuring this occurs.</p>
<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>	<p>FA</p>	<p>The infection control policy includes a surveillance policy that includes a surveillance procedure, process for detection of infection, infections under surveillance, outbreaks and quality and risk management. Infection events meeting the standard definitions are entered into the electronic system and collated monthly. The infection control coordinator provides infection control data, trends and relevant information to the infection control committee, quality improvement and clinical meetings. Areas for improvement are identified, corrective actions developed and followed up. 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. Meeting minutes, reports and graphs are displayed in the staff room.</p> <p>There have been two outbreaks in 2019. A norovirus outbreak was in May 2019 and an influenza (positive A) was in July 2019. Public Health was notified in both cases and case logs (sighted) were emailed daily to public health. The service held PowerPoint debriefs post outbreak and a written summary of each outbreak was available.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>There are policies around restraints and enablers. The restraint coordinator (CNL) oversees restraint minimisation for the service and has a job description that outlines the responsibility of the role. The service currently has two hospital residents assessed as requiring the use of restraint (one bed rails and one T-belt) and one hospital resident with two enablers (bedrail and lap belt). Restraint is used as a last resort where alternative strategies have not been successful in maintaining resident safety. Residents voluntarily request and consent to enabler use. Staff receive training around restraint minimisation that includes annual competency assessments.</p>
<p>Standard 2.2.1: Restraint approval and processes</p>	<p>FA</p>	<p>A restraint approval process and a job description for the restraint coordinator are in place. Discussion around restraint use and approval is on the agenda at the RN monthly meetings. All staff are required to</p>

Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.		attend restraint minimisation training annually and complete restraint competencies. Care plans include restraint or enabler use and the duration of restraint.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	Restraint assessments are based on information in the resident's care plan, discussions with the resident and family, observations by staff and monitoring of any resident accidents/incidents. A restraint assessment tool meets the requirements (a-h) of the standard. Two hospital level residents' files where restraint was being used (one resident had two restraints) were selected for review. Each file included a restraint assessment and consent form that was signed by the resident's family and GP. The assessment identifies risks associated with the type of restraint applied. Restraint use and risks are linked to the resident's care plan and is regularly reviewed by the restraint coordinator, RNs and GP.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	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 on the electronic system when the restraint is put on and when it is taken off, however there were gaps in monitoring documentation (link 1.3.6.1).
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	Restraint use is reviewed three monthly by the restraint coordinator and the RNs at the monthly RN meeting. The review process includes discussing whether continued use of restraint is indicated and (a) to (k) as listed. The GP reviews restraint use at the three-monthly medical review.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of	FA	The restraint programme, including reviewing policies and procedures and staff education is evaluated annually by the regional quality manager in consultation with the restraint coordinator. Internal audits monitor compliance of the standard.

their use of restraint.		
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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	PA Low	Overall care plans indicated the required support and/or interventions needed by the individual resident to achieve desired outcomes and these are evaluated six monthly or as needs change. However, identified risks and interventions were not identified for two insulin dependent residents.	<p>Two insulin dependent hospital residents had limited information recorded in their plans to direct staff to make relevant observations and actions to take in their plans of care.</p> <p>For example, there was no detail as to observations to make for hyper/hypoglycaemia and no instructions in relation to foot care. One of these residents was also on warfarin with no instructions to staff as to relevant observations or risks related to warfarin treatment.</p>	<p>Ensure there are diabetic management plans in place for insulin dependent residents. Ensure risks and observations are documented for residents on warfarin.</p> <p>90 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or</p>	PA Low	Monitoring forms were utilised to monitor a residents' progress; however, restraint/enabler monitoring and neurological observations had not been	(i) Five of five neurological observation charts for unwitnessed falls had not been completed as per protocol. (ii) Restraint monitoring for two residents on restraint and	(i) Ensure neurological observations are completed as per

<p>interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>		<p>completed as required.</p>	<p>monitoring for one resident with enablers did not have monitoring documented as completed at the frequency determined in the care plan.</p>	<p>protocol. (ii) Ensure restraint and enabler monitoring is completed at the required frequency.</p> <p>90 days</p>
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.1.4.2 Māori consumers have access to appropriate services, and barriers to access within the control of the organisation are	CI	Summerset by the Ranges is recognised as a leading provider in terms of individualised Māori health. The service has a Māori Cultural Advisor who has developed excellent	The Māori Cultural Advisor was appointed a year ago and has been integral in leading and navigating and supporting staff in the provision of appropriate care and culture of our Māori residents. She has completed papers in tikanga, Māori education, dementia training and progressing through diversional therapy units. The Māori Cultural Advisor is very knowledgeable in Māori traditions, customs and tikanga and has continued Māori cultural teachings that have been passed through generations of kuia and kaumātua. The Maori Cultural Advisor, village kuia and local kaumātua have reviewed the Summerset by the Ranges Maori health plan. The tikanga flip chart is being reviewed for local appropriateness. The role of the Māori Cultural Advisor is documented and known to staff and includes being available to consult with staff, residents and families on all areas of cultural support, end of life support, translation and interpreter services for Māori. Kaumātua led the blessing of the whenua prior to the build of the dementia care unit which has established strong community links to the dementia care unit. All resident rooms are blessed following the death of residents. The service encourages the use of te reo Māori in everyday interactions such as display of date, times, signage in Māori and English. Staff are encouraged to use Māori greetings and phrases which is followed through into the newsletters. The Māori Cultural Advisor and the diversional therapist have recently completed training in spin poi as part of DT training and implemented this as a regular activity improving cognitive stimulation and interaction among residents (demonstrated by video). The Māori

identified and eliminated.		relationships with key Māori stakeholders in the local community.	Cultural Advisor has goals to set up a village kapa haka group and poi group.
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>The service has worked collaboratively with the nurse practitioner at the hospice to implement the Te Ara Whakapiri last days of life pathway to improve the quality of care for residents at the end of life. There have been no facility-acquired pressure injuries for the last year.</p>	<p>1) In 2018 the service completed SEQUAL education and end of life care in consultation with the hospice nurse practitioner (NP). The NP (interviewed) spent 3-5 “shadow” shifts working alongside each RN and caregiver, delivering beside education and providing palliative care support for staff, residents and families. The NP stated there was a great willingness of staff to learn and upskill to support the residents. The RNs became more confident in assessing residents who could benefit from palliative support and symptom management. The service then commenced the Te Ara Whakapiri – “The path to closeness and Unity” for the last days of life when it was introduced by hospice. The goal is to provide optimal care to residents in their last days of life and to support their family/whānau as they support their loved one on this journey. Many staff had attended palliative care courses and have received continuing education. All newly employed caregivers complete the fundamentals of palliative care course and all RNs attend the two days palliative care course at hospice. The NP stated the RNs and caregivers work together well as a team and are competent in assessing and developing a plan of care, including symptom management should the resident deteriorate. The plan includes the resident and family choice and ensures the difficult conversations have taken place. There is a good working relationship between the staff and the NP who is readily available to support the staff, resident and family as required. The GP (interviewed) is supportive of the Te Ara Whakapiri pathway and stated the staff provide very good end of life care. There is a palliative care pack available that includes aromatherapy, moisturisers and care products. The family are also cared for with refreshments and uninterrupted quality time with their loved one including assisting with cares if they choose to. There were cards and letters of grateful thanks for the loving care provided by staff at Summerset by the Ranges.</p> <p>2) Pressure injury prevention education, early reporting of skin integrity concerns, pressure relieving resources and good hygiene, personal cares and repositioning are evidenced in the pressure injury statistics over the last year. The last facility-acquired pressure injury was a stage 1 sacral split in February 2019. There were two palliative residents admitted with pressure injuries in 2019. The CNL is the wound champion for the service. All the current RNs have attended pressure injury prevention and wound care. Residents have nutritional assessments and continence assessments with interventions documented in care plans. The average pressure injury rate over 2019 was 0.25 compared with the Summerset average of 0.4 – 0.5. There was only one wound on the day of audit (basal cell carcinoma).</p>

End of the report.