Summerset Care Limited - Summerset on Summerhill

Introduction

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

The audit has been conducted by BSI Group New Zealand Ltd, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Summerset Care Limited
Premises audited:	Summerset on Summerhill
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 4 March 2021 End date: 5 March 2021

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: 40

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Summerset on Summerhill is part of the Summerset group and provides rest home and hospital level care for up to 45 residents. On the day of the audit, there were 40 residents.

This certification audit was conducted against the relevant Health and Disability Services 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 nurse practitioner.

The service is managed by a village manager and a care centre manager. There are quality systems and processes being implemented. An induction and in-service training programme is in place to provide staff with appropriate knowledge and skills to deliver care. The residents and relatives interviewed spoke positively about the care and support provided.

This audit identified an improvement required around interventions.

The service has achieved a continuous improvement rating around planned activities.

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.

Policies are documented to support resident rights. Systems protect their physical privacy and promote their independence. There is a documented Māori health plan in place which acknowledges the principles of the Treaty of Waitangi. Individual care plans include reference to residents' values and beliefs.

Residents and relatives are kept up to date when changes occur or when an incident occurs. Systems are in place to ensure residents are provided with appropriate information to assist them to make informed choices and give informed consent.

A complaints policy is documented that aligns with the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). A complaints register is maintained.

Consents are documented by residents or family and there are advance directives documented if the resident is competent to complete these.

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.

Organisational performance is monitored through several processes to ensure it aligns with the identified values, scope, and strategic direction. The business plan is tailored to reflect the goals related to Summerset on Summerhill. There are policies and procedures to provide appropriate support and care to residents with hospital and rest home level needs. This includes a

documented quality and risk management programme that includes analysis of data. Meetings are held at regular intervals to discuss quality and risk management and to ensure these are further embedded into practice. There is a health and safety management programme that is implemented with evidence that issues are addressed in a timely manner.

An orientation programme is in place and there is ongoing training provided as per the training plan developed for 2020. Rosters and interviews indicate sufficient staff that are appropriately skilled, with flexibility of staffing around clients' needs. A roster provides sufficient and appropriate coverage for the effective delivery of care and support including planned staffing for the rest home residents in serviced apartments. Registered nursing cover is provided twenty-four hours a day, seven days a week.

The residents' files are appropriate to the service type.

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 medium or high risk and/or unattained and of low risk.

The service has assessment processes and resident's needs are assessed prior to entry. There is a comprehensive pack available for residents and families/whānau at entry. Assessments, resident care plans, and evaluations were completed by the clinical nurse leader and registered nurses within the required timeframes. Risk assessment tools and monitoring forms were available and implemented. Resident care plans were individualised and included allied health professional involvement in resident care.

A diversional therapist and team of volunteers implement an integrated activity programme. The activities meet the individual recreational needs and preferences of the resident groups. There are outings into the community and visiting guests/entertainers.

There are medicine management policies in place that meets legislative requirements. Staff responsible for the administration of medications complete annual medication competencies and education. The general practitioner reviews the medication charts three monthly.

The food service is contracted to an external company. Resident's individual dietary needs were identified and accommodated. Staff have attended food safety and hygiene training.

Safe and appropriate environment

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

There were documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Chemicals were stored safely throughout the facility. The building has a current warrant of fitness. Resident rooms and bathroom facilities are spacious. All communal areas within the facility are easily accessible. The outdoor areas are safe and easily accessible and provide seating and shade. The service has implemented policies and procedures for civil defence and other emergencies and six-monthly fire drills are conducted. There is a first aid trained staff member on duty 24 hours. Housekeeping/laundry staff maintain a clean and tidy environment. There is plenty of natural light in all rooms and the environment is comfortable with adequate ventilation and heating.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.

Restraint minimisation and safe practice policies are in place to guide staff in the use of an approved enabler and/or restraint. On the day of audit there were five residents using restraint and two with an enabler. Staff training has been provided around restraint minimisation and management of challenging behaviours. The restraint coordinator (clinical nurse manager), and staff have worked to identify individual strategies for residents other than using bedrails.

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 (the care centre manager) is responsible for coordinating and providing education and training for staff. The infection control manual outlined the scope of the programme and included a comprehensive range of 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 Summerset facilities.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	1	48	0	0	1	0	0
Criteria	1	99	0	0	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The Health and Disability Commissioner's (HDC) Code of Health and Disability Consumers' Rights (the Code) brochures are accessible to residents and their families. The policy relating to the Code is implemented and staff interviewed (four caregivers, two registered nurses (RN), one recreational therapist, one property manager, three managers, one housekeeper, one laundry staff and the chef) could describe how the Code is incorporated into their everyday delivery of care. Staff receive training about the Code during their induction to the service, which continues annually through the staff education and training programme.
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	There are policies and procedures in place for informed consent. Written general and specific consents were evident in the seven resident files reviewed (three rest home level including one respite care and four hospital level including one resident under chronic medical illness contract and one resident under oncology care contract). Permission granted were also included in the admission agreement for long-term and short-term residents. Registered nurses and caregivers interviewed confirmed consent is obtained when delivering cares. Resuscitation orders had been appropriately signed by the resident and general practitioner (GP). Where the resident is deemed unable to make a decision the GP makes a medical decision in consultation with the enduring power of attorney. The service acknowledges the resident is for resuscitation in the absence

		of a signed directive by the resident. Advance care plans where available were kept on the resident file. Discussion with family members identified that the service actively involves them in decisions that affect their relative's lives. Admission agreements for permanent and short-stay residents were sighted and signed.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Information on advocacy services is included in the resident information pack that is provided to new residents and their family on admission. Advocacy brochures are also available at reception. Interviews with residents and family confirmed their understanding of the availability of advocacy services. The complaints process is linked to advocacy services with this offered to any complainant if required. Staff receive regular education and training on the role of advocacy services, which begins during their induction to the service with training records confirming this.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	The service has an open visiting policy. Residents may have visitors of their choice at any time and family interviewed confirmed that they can visit whenever they like. The main doors lock automatically at dusk and independent residents hold a swipe card to enter the building after doors are locked. Family is able to ring through to the RN if they wish to visit after hours. The service encourages the residents to maintain their relationships with their friends and community groups. Assistance is provided by the care staff to ensure that the residents participate in as much as they can safely and desire to do as observed during the audit.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The organisational complaints policy states that the village manager has overall responsibility for ensuring all complaints (verbal or written) are fully documented and investigated. The care centre manager is responsible at this facility for addressing any complaints in consultation with the village manager. A complaints procedure is provided to residents within the information pack at entry. Feedback forms are available for residents/family members in various places around the facility. There is a complaints' register that includes relevant information regarding the complaint. There have been six formal complaints lodged in 2020. All were reviewed, and this confirmed that complaints are responded to in a timely manner as per policy with each complainant confirming that they were happy with the outcome. Five of six complaints raised during 2020 related to staff being rough, unpleasant, uncaring and or lacking respect. The new village manager (who commenced January 2021) has developed an action plan to

		address this trend. The action plan was due to roll out at the time of audit. Residents and family interviewed stated that they felt they could complain at any time and those that had stated that their concerns had been dealt with in a timely manner to their satisfaction. They also stated that the new managers were 'extremely competent and visible' which allowed for discussion and encouraged any concerns to be raised.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Details relating to the Code and the Health and Disability Advocacy Service are included in the resident information folder that is provided to new residents and their families. On admission an RN discusses aspects of the Code with residents and their family on admission. Discussions relating to the Code are also held during the resident family meetings. Six residents interviewed (three rest home and three requiring hospital level care) confirmed that they received cares that met their needs, and all were aware of their rights. Four family members interviewed (all with family requiring hospital level care) confirmed that staff had informed them of the Code.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	The residents' personal belongings are used to decorate their rooms. Rooms have ensuites and there are communal toilets as well. All have locks to ensure privacy. The caregivers interviewed reported that they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas. This was observed to occur during the audit. Caregivers reported that they promote the residents' independence by encouraging them to be as active as possible. All the residents and families interviewed confirmed that residents' privacy is respected. Guidelines on abuse and neglect are documented in policy. Staff receive annual education and training on abuse and neglect, which begins during their induction to the service. Complaints reviewed for 2020 evidenced that five of six complaints were related to staff being rough, unpleasant, and or lacked respect. There is an action plan in place for this issue (link 1.1.13). There are spiritual services and residents are encouraged to attend their own spiritual care in the community. There is at least one church service a week. Any resident or family member can attend. Spiritual needs are individually identified as part of the assessment and care planning process.
Standard 1.1.4: Recognition Of Māori Values And Beliefs	FA	The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. The care staff interviewed reported that

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.		they value and encourage active participation and input from the family/whānau in the day-to-day care of the resident. There were no residents living at the facility who identified as Māori. The village manager (who identifies as Māori) is working with local iwi to strengthen links and work with them to provide improved access and services for Māori. Staff receive annual education on cultural awareness that begins during their induction to the service. There is a draft Māori health plan with goals to improve outcomes for residents, the plan is currently with the local iwi for comment. The service can also access support through the Māori Health Unit at the district health board if required.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	The service identifies the residents' personal needs and desires from the time of admission. This is achieved in collaboration with the resident, family and/or their representative. Staff interviewed confirmed that they are committed to ensuring each resident remains a person, even in a state of decline. Beliefs and values are discussed and incorporated into the care plan as sighted in the review of seven resident records reviewed. Residents and families interviewed confirmed they are involved in developing the resident's plan of care, which includes the identification of individual values and beliefs.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	There are implemented policies and procedures to protect clients from abuse, including discrimination, coercion, harassment, and exploitation, along with actions to be taken if there is inappropriate or unlawful conduct. Expected staff practice is outlined in job descriptions. Staff interviewed demonstrated an awareness of the importance of maintaining professional boundaries with residents. Residents interviewed stated that they have not experienced any discrimination, coercion, bullying, sexual harassment, or financial exploitation. Professional boundaries are reconfirmed through education and training sessions and staff meetings, and managers stated that performance management would address any concerns if there was discrimination noted.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service meets the individualised needs of residents who have been assessed as requiring rest home or hospital level care as identified through interviews with care staff and through an audit of resident files. The village manager has worked at Summerset on Summerhill for many years as the administration manager. She has implemented a process of staff involvement and communication in many areas including developing the business and quality plan for the service. Community links are an area she is

		strengthening such as local Māori groups and local community groups. The service has policies and procedures, equipment, and resources to support ongoing care of residents. The quality programme has been designed to monitor contractual and standards compliance and the quality-of-service delivery in the facility. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. Meetings are conducted to allow for timely discussion of service delivery and quality of service including health and safety. Residents interviewed spoke very positively about the care and support provided. Staff interviewed had a sound understanding of principles of aged care and stated that they are supported by the management team. Caregivers' complete competencies relevant to their practice. The nurse practitioner interviewed was satisfied with the care that is being provided by the service.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents interviewed, confirmed they were given an explanation about the services and procedures and were orientated to the facility as part of the entry process. They also stated their relatives are informed of changes in health status and incidents/accidents with family interviewed confirming that they were kept informed at all times. A review of ten incident forms confirmed that family were informed in a timely manner when incidents occurred. Family interviewed also confirmed they were informed at all times. Resident/family meetings have occurred monthly (other than during the Covid lockdown). Residents and family interviewed confirmed that the care centre manager and the village manager are readily available and helpful. The regional quality manager interviewed also stated that the managers discuss how they can improve resident outcomes on a regular basis. 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). If residents or family/whānau have difficulty with written or spoken English, the interpreter services are made available through the district health board with phone numbers identified in policy. There are staff on site who speak a range of languages including te reo Māori. There are no residents currently requiring the use of interpreting services.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of	FA	Summerset on Summerhill is certified to provide rest home and hospital (medical and geriatric) levels of care in their care facility for up to 45, including two dedicated oncology beds funded by the DHB. On the day of the audit there were 40 residents requiring hospital or rest home level of care. There were 10 at rest home level, including one respite resident and 30 at hospital level including one oncology resident, two health care recovery residents and one funded through a specialist DHB contract. All others are funded through the Age-Related Care Contract. All residents' rooms in the care facility are identified as

consumers.		dual-purpose. A village manager (VM) is responsible for the retirement village. The VM was appointed January 2021 having been the administration manager for the service for many years. The previous manager had trained and mentored the new manager for this role over a two-year period. She is supported by a care centre manager (registered nurse with a current annual practicing certificate) who has many years health management experience with relevant training and who was clinical nurse leader at this facility prior to this role. The new management team are supported well with a regional quality manager. Summerset group has a well-established organisational structure. Each of the Summerset facilities throughout New Zealand is supported by this structure. The regional quality manager supported the team on the day of audit and there are managers meetings weekly. The Summerset group has a comprehensive suite of policies and procedures, which guides 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 on Summerhill has a site-specific 2020 business plan and goals that has been reviewed quarterly. The 2021 quality and business plan was in the process of consultation at the time of report. It had been developed with the staff team care centre manager and regional quality manager. The philosophy, vision and values of the organisation are documented and able to be articulated by staff when interviewed. The managers had all attended at least eight hours of leadership professional development and/or clinical training relevant to the role.
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	FA	The village manager is responsible for the administrative functions of the facility and the care centre manager is responsible for operational management of the service and provides oversight of clinical care. The office manager would work with the care centre manager to relieve for the village manager if they were on leave and the village manager would relieve for the care centre manager when away.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and	FA	There is an established 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

maintained quality and risk management system that reflects continuous quality improvement principles.		allow effective implementation by staff. The Summerset group has a quality assurance framework 2021 calendar. The calendar schedules the training, meetings, and audit requirements for the month. The annual residents/relatives survey for the service was last completed during 2020. The survey results showed a marked improvement from 2019. There is a meeting schedule that includes monthly meetings as follows: quality improvement; caregiver; registered nurse; and resident meetings. The monthly quality and monthly care staff meetings include discussion about clinical indicators (eg, incident trends, infection rates). Infection control and restraint meetings have occurred monthly (apart from during Covid lockdown periods) as part of the RN meetings. There is also a weekly management meeting. The service is implementing an internal audit programme that includes aspects of clinical care. Issues arising from internal audits are developed into corrective action plans with evidence of resolution of issues as these are identified. 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 with this compared to other Summerset services of similar size and composition. Infection control is also included as part of benchmarking across the organisation. Health and safety internal audits are completed. Summerset's clinical and quality managers analyse data collected via the monthly reports and corrective actions are required based on benchmarking outcomes. There is a health and safety and risk management programme in place including policies to guide practice. There is a health and safety plan with evidence of review at the health and safety meetings. There are health and safety representatives. The service addresses health and safety by recording hazards and near misses, sharing of health and safety information and actively encourage staff input and feedback. The service ensures that all new staff and any contractors are inducted to the health and safety programme with a health and safety competency completed by staff as part of orientation (staff records confirmed that these had been completed). Falls prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the	FA	Incident and accident data is being collected and analysed. A review of ten incident/accident forms identified they were all fully completed, including follow-up by a registered nurse and that family had been notified. Post-falls assessments included neurological observations for unwitnessed falls and were completed as per policy. Near misses are also reported through the incident reporting system. The incident reporting policy includes definitions and outlines responsibilities including immediate action,

service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.		reporting, monitoring and corrective action to minimise and debriefing. Post incident and accident review was noted to be very thorough with comprehensive RN review as well as root cause analysis for more serious incidents. Root cause analysis reviews included: four section 31 notifications for pressure injuries, and non-section 31 issues such as (but not limited to); two resident falls, two medication issues, and one aggressive episode. The reviews all included an action plan; all of which had been evaluated and signed off. Data is linked to the organisation's benchmarking programme and used for comparative purposes. Discussions with the management team confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	There are human resources policies to support recruitment practices. Nine staff files (one care centre manager, one activities person, three registered nurses, three caregivers, and a housekeeper) were reviewed and all had relevant documentation relating to employment. Performance appraisals have been completed annually. Copies of annual practising certificates are on file and a review confirmed that these were current including RNs and external providers requiring these. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and believed new staff were orientated well into the service. The orientation programme includes a buddy system with the new staff member working alongside an experienced care staff member for five days. Care staff complete competencies as part of orientation relevant to their role. One new staff interviewed confirmed that they had a relevant and comprehensive orientation. There is an annual education plan in place. The 2020 and 2021 education plan has been implemented and staff stated that this is relevant to their role. A competency programme is in place with different requirements according to work type (eg, caregivers, RNs, and kitchen). Core competencies are completed, with a record of completion maintained. Staff interviewed were aware of the requirement to complete competency training. The service has ten RNs (including the care centre manager) and seven trained in interRAI. RNs complete online learning through Ko Awatea.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled	FA	Staffing levels and skills mix policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery. There are clear guidelines for increase in staffing depending on acuity of residents. A staff availability list ensures that staff sickness and vacant shifts are covered, and a review of rosters for a three-week period confirmed that staff are replaced when on leave. Interviews with residents and relatives confirmed that staffing levels are sufficient to meet the needs of

and/or experienced service providers.		residents. The village manager and care centre manager both work 40 hours per week from Monday to Friday and are available on call for any emergency issues or clinical support. The service has three wings each are staffed separately. The service provides 24-hour RN cover with two RNs on the morning and afternoon shifts and one overnight. Caregivers interviewed stated that they help each other out as needed. A wing has five hospital level residents and four at rest home level. The AM and the PM shifts each have one long shift and one short shift. B wing has 13 residents at hospital level and three at rest home level. The AM shift has two full shifts. The PM shift has one long and one short shift. C wing has 12 hospital level residents and three at rest home level. The AM shift has two full shifts. The PM shift has one long and one short shift. There are two caregivers on duty at night. The clinical nurse manager and the care centre manager are on call after hours.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The residents' files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24-hours of entry into each resident's individual record. An initial support plan is also developed in this time. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access by being held in a secure room. Archived records are secure in separate locked areas. Residents' files demonstrated service integration. Entries are legible, dated, timed, and signed by the relevant caregiver or nurse, including designation.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	All residents have a needs assessment completed prior to entry that identifies the level of care required. The care centre manager screens all potential enquiries to ensure the service can meet the required level of care and specific needs of the resident. A welcome pack provides relevant information regarding the service and care provided and includes a brochure on falls prevention and pressure injury prevention. Residents and relatives interviewed stated that they received sufficient information on admission and discussion was held regarding the admission agreement. The admission agreement reviewed aligns with a) - k) of the ARC contract.

Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	There is an exit discharge and transfer policy that describes guidelines for death, discharge, transfer, documentation and follow-up. All relevant information is documented and communicated to the receiving health provider or service. The service uses a pink envelope transfer system which includes all the required documentation and there is a discharge checklist for DHB use. The facility ensures residents are accompanied by care staff to hospital and stay until a family member arrives. Follow-up occurs to check that the resident is settled or, in the case of death, communication with the family is made.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	There are medicine management policies and procedures that align with recognised standards and guidelines for safe medicine management practice. The RNs are responsible for the administration of medications and some caregivers have completed medication competencies for the checking and witnessing of medications and medication round if required. Staff complete annual medication competencies and medication education. All medications are stored safely. All medications (in robotic rolls) were evidenced to be checked on delivery with any discrepancies fed back to the supplying pharmacy. There is a hospital stock of medications which are checked weekly. Eye drops are dated on opening. There were three self-medicating residents (two rest home and one hospital) with current self-medication competences. The medication fridge is monitored daily and records any corrective actions for temperatures outside of the acceptable range. The medication room has an air conditioning unit set at 18 degrees Celsius. Fourteen resident medication charts on the electronic medication system were reviewed. The medication charts had photograph identification and allergy status recorded. Staff recorded the time, date and the outcomes of ‘as required’ medications. All ‘as required’ medications had an indication for use. All medication charts had been reviewed by the GP three-monthly.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	The service has a contracted company for the provision of all meals on site. The kitchen is adjacent to the dining room with meals served directly to residents from a bain marie in the kitchen. There is a qualified chef on each duty supported by a kitchenhand 9 am-7 pm. All staff have received food safety and hygiene training. There is a six-week rotating summer menu that has been reviewed by the organisational dietitian last in January 2021. Summerset staff prepare and serve breakfast. The main meal is at midday. The menu has a vegetarian option. Pureed, soft and diabetic diets are provided as required. The chef receives a dietary profile for each resident. Resident likes/dislikes and allergies are known and accommodated with alternative meal options. The service has a current food control plan issued 1 January 2021 for a period of one year. A food safe pro electronic system is used for the recording of dishwasher checks, end cooked food temperatures, serving temperatures, inward goods, fridge and freezer checks. Daily checklists and cleaning schedules

		are maintained. Staff were observed wearing correct personal protective clothing. The chemical provider completes a functional test on the dishwasher three monthly. Residents have the opportunity to feedback on meals through direct feedback, resident meetings and surveys. Residents and relatives commented positively on the meals provided.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	The reason for declining service entry to potential residents should this occur is communicated to the potential resident or family/whānau and they are referred to the original referral agent for further information. The reason for declining entry would be if the service was unable to provide the level of care required or if there were no beds available.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	The initial assessment including the risk assessment tools (as applicable) are developed with information received on admission (link 1.3.6.1), including discussion with the resident and relatives and referring agency, for all long-term and short-stay residents. Risk assessments are reviewed six-monthly as part of the interRAI assessment. Outcomes of risk assessment tools and interRAI assessment are used to identify the needs, supports and interventions required to meet resident goals of permanent residents with links to the long-term care plan. The interRAI assessment tool has been utilised six-monthly for all long-term residents under the aged residential care contract. (ARCC).
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Care plans for long-term residents describe the individual support and interventions required to meet the resident goals. The care plans reflect the outcomes of risk assessment tools and the interRAI assessment. Care plans demonstrate service integration and include input from allied health practitioners. The respite care resident, CMI resident and oncology stay resident had an initial assessment and initial support plan in place. The CMI resident had a plan of care developed by hospice which was included in the resident file. Short-term care plans were in use for changes in health status such as infections, wounds and pressure injury (link 1.3.6.1). These are evaluated regularly and either resolved or if an ongoing problem added to the long-term care plan. There is documented evidence of resident/family involvement in the care planning process. Residents/relatives interviewed confirmed they participate in the care planning process.

Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Moderate	When a resident's condition changes, the RN initiates a review and if required a GP, NP or nurse specialist consultation. ISBAR forms are used to document the RN clinical assessments. Relatives interviewed stated their relative's needs are met and they are kept informed of any health changes. There was documented evidence in the electronic resident files of family notification of any changes to health including infections, accidents/incidents, GP/NP visits and medication changes. Residents interviewed stated their needs are being met. Not all interventions had been documented or implemented. Adequate dressing supplies were sighted. Initial wound assessments with ongoing wound evaluations and treatment plans were in place for ten residents with wounds (lesions, blister, abrasions and chronic wounds). Photographs and evaluations demonstrate progress to healing. One chronic wound and one ulcer was linked to the long-term care plans. There is an RN wound care nurse for the facility and there is access to wound nurse specialist advice at the DHB. There was one stage 2 pressure injury of the sacrum on admission. Wound assessment, photograph and ongoing evaluations were documented. There were sufficient pressure injury resources and equipment available including air alternating mattresses and pressure relieving cushions. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed. Monitoring forms are maintained on the electronic resident management system.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	CI	The diversional therapist (DT) is a registered midwife and completed a PHD in social interaction and behaviour in 2017. She works full-time Friday to Tuesday. The DT is supported by a part-time recreational officer who works Wednesdays and Thursdays. A monthly calendar of activities and events is displayed and seen in resident rooms. A larger print weekly programme is also available and displayed. The programme commences at 10.30 am until 3.30-4 pm. The programme provides many group and individual activities to meet the hospital and rest home resident's recreational preferences and interests including (but not limited to) exercises (chair, yoga or dance), walks, word games and quizzes, board games, carpet bowls, stories and reminiscing, music and movies, happy hour, news and current affairs, arts and crafts. The service improved pet therapy sessions for residents from regular weekly sessions to everyday interactions with two puppies who became part of the Summerhill family. One-on-one contact is made daily with residents who are unable to or choose not to participate in group activities. Pampering and hand and nail care, chats and reminiscing activities were included for one-on-one time and a volunteer visits residents regularly. The cognitive stimulation therapy (CST) for residents with dementia continues and is included in the overall programme. There are a ladies and men's group that meet weekly to participate in activities, outings of interest to the group. The DT has introduced

		sensory stimulation therapy (SST) with activities that encourage residents with dementia to communicate and engage with staff, families and other residents. Outings and entertainment have recommenced following Covid-19 restrictions. The weekly van outings accommodate one resident with a wheelchair. There are a higher number of hospital residents with declining mobility unable to attend community functions. Community visitors come into the care centre and include musical entertainers and church groups. Festive occasions, events and birthdays are celebrated. Resident meetings, family meeting and surveys provide an opportunity for residents to feedback on the programme. The DT is involved in the multidisciplinary review which includes the review of the activity plan. The DT works Saturdays and Sundays and has the opportunity to meet with the visiting families.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	There is evidence of resident and family involvement in the review of long-term resident care plans. Written evaluations for long-term residents were completed six-monthly. The multidisciplinary (MDT) team including the GP/NP, care staff and other health professional's involvement in the resident's care are asked for input. Goals of care are evaluated, and changes are made to the care plan where goals have not been met. Families are invited to attend the MDT review and asked for input if they are unable to attend. Copies of care plans are offered to the family. The resident/relative signs a care plan acknowledgement form. Short-term care plans sighted have been evaluated by the RN. The GP completes three monthly reviews.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Medical and specialist referrals are made by the GP/NP. Registered nurses make referrals to external nurse specialists such as diabetes nurse, speech language therapist and wound nurse specialist.
Standard 1.4.1: Management Of Waste And Hazardous	FA	Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Safety datasheets and product sheets were readily accessible for staff. Chemicals were stored safely throughout the facility. Personal protective clothing was available

Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.		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.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building is two levels with the care centre on the ground floor and staff only areas upstairs. The building has a current building warrant of fitness that expires on 24 July 2021. A full-time property manager of the care centre and villas (also available on-call) oversees a property assistant and two gardeners. The property manager has completed a health and safety course level three and first aid. Maintenance requests for repairs are logged onto the online system where they are actioned and signed off when completed. There are preferred contractors available 24 hours. Monthly planned maintenance duties are set by head office. These include resident related and environmental planned maintenance and signed off when completed. All electrical equipment has been tested and tagged. Clinical equipment has had functional checks/calibration annually. New boilers were installed October 2020. Hot water temperatures have been tested and recorded monthly with readings below 45 degrees Celsius (as sighted on the online system). Refurbishment of all resident rooms has almost finished and there are plans for refurbishment of the lounge and dining area. Corridors are wide in all areas to allow residents to pass each other safely. There is safe access to all communal areas and outdoor areas. Outdoor areas provide seating and shade. The external areas are well maintained. The caregivers (interviewed) stated they have all the equipment required to safely provide the care documented in the care plans.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving	FA	There are three wings of resident rooms. All rooms are single. One wing of resident rooms has either own or shared ensuites with privacy locks. All other resident rooms have hand basins and access to adequate numbers of shared shower/toilet facilities with privacy locks. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. Resident interviewed confirmed the care staff respect their privacy when attending to their personal cares.

assistance with personal hygiene requirements.		
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	There is adequate room to safely manoeuvre mobility aids and transferring equipment such as a hoist, as needed for cares and transfer of residents. The doors are wide enough for ambulance trolley access. Residents and families are encouraged to personalise their rooms as viewed on the day of audit.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	Communal areas within the facility include a large main lounge and dining room. There is also a conservatory lounge/additional dining area in the main communal area. In one wing there is a sun lounge/family room with tea/coffee making facilities. There are several seating alcoves within the facility. The communal areas and outdoor patios and courtyards are easily accessible for residents.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	There are adequate policies and procedures to provide guidelines including Covid-19 precautions, regarding the safe and efficient use of laundry services. All linen and personal clothing is laundered on site during the night (11 pm-6 am) by a dedicated laundry person seven days a week. There is a defined clean/dirty area with an entry and exit door. The laundry facility is well equipped, and all machinery has been serviced regularly. There are dedicated cleaning staff on duty daily 8.30 am-3 pm. There is an additional cleaner 4.30 pm-8 pm who carries out additional cleaning requirements. The cleaning trolley sighted was well equipped and had a locked chemical box for chemicals when not in use. The trolley is stored in the locked chemical cupboard. There are safety datasheets and product sheets available. All chemicals are dispensed through an auto dispenser. Internal audits monitor the effectiveness of laundry and cleaning processes. The chemical provider monitors the laundry and cleaning processes for effectiveness. Cleaning and laundry staff have completed chemical safety training, infection control and Covid-19 education.
Standard 1.4.7: Essential, Emergency, And Security Systems	FA	There are emergency and disaster manuals to guide staff in managing emergencies and disasters. Emergencies, first aid and CPR are included in the mandatory in-service programme. There is a first aid trained staff member on duty 24 hours. Appropriate training, information, and equipment for responding to

Consumers receive an appropriate and timely response during emergency and security situations.		emergencies is provided. There is an approved evacuation plan. Fire evacuations are held six-monthly, and the last drill was completed 16 November 2020. The civil defence cupboard is well equipped and checked regularly. There is sufficient water, food and alternative cooking in the event of an emergency. There is a generator available on site. During the tour of the facility, residents were observed to have easy access to the call bells, and residents interviewed stated their bells were answered in a timely manner. Call bell audits are carried out monthly. The facility is secured at night.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	Visual inspection evidenced that the residents have adequate natural light in the bedrooms and communal rooms, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. There is underfloor heating throughout the facility. An air conditioning unit has been installed in the lounge. There were portable air movers in corridors to reduce heat on the day of audit. There is a plan for these to be replaced by ceiling fans in the near future.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	The infection control programme is appropriate for the size and complexity of the service. There is an infection control responsibility policy that includes responsibilities for the infection control officer. The infection control (RN) has been in the role since April 2020 and has a signed job description outlining the responsibilities of the role. The infection control programme is linked into the quality management system and reviewed annually at head office in consultation with the infection control committee. The facility meetings include a discussion of infection control matters. Visitors are asked not to visit if they are unwell. All visitors including contractors are required to declare their wellbeing (implemented during Covid-19) when signing in on the electronic register. Covid-19 precaution notices and hand sanitisers are available at facility entrances. Influenza vaccines are offered to residents and staff. Hand sanitisers are available throughout the facility.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the	FA	There is monthly “zoom” meetings with all organisational infection control coordinators and the Summerset infection control lead coordinator. The infection control committee comprises of a cross section of staff from areas of the service including housekeeping and kitchen services. The infection control team meet monthly and provide reports to head office and facility meetings. The infection control team has access to an infection control nurse specialist at the DHB, laboratory, pharmacy, GPs and expertise within the organisation. The regional quality manager oversees infection control across the facilities.

organisation.		
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	Policies and procedures are developed and reviewed at head office in consultation with infection control coordinators. Policies are available to all staff. They are notified of any new/reviewed policies and are required to read and sign for these.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control coordinator is responsible for coordinating and providing education and training to staff. The induction package includes specific training around handwashing competencies and standard precautions. Ongoing training occurs annually as part of the training calendar set at head office. Registered nurses complete the infection control with Ko Awatea online learning. A Covid-19 resource folder was available with practical sessions provided on the correct use of personal protective clothing and isolation procedures. Resident education occurs as part of providing daily cares. Care plans can include ways to assist staff in ensuring this occurs.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The infection control surveillance policy includes a surveillance procedure, process for detection of infection, infections under surveillance, outbreaks and quality and risk management. Infection events are reported, collected monthly and entered into the electronic system. The infection control coordinator provides infection control data, trends and relevant information to the infection control committee and clinical/quality meetings. Meeting minutes are available to staff who read and sign the reading form. The facility is benchmarked against other Summerset facilities of similar size and benchmarking results are fed back to the infection control coordinator and used to identify areas for improvement. Improvements are identified and analysed with corrective actions developed and followed up. Additional education is provided at handovers where upward trends for infections have been identified. Reports and graphs are

		available in the staff room. There have been no outbreaks.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. The use of restraint is a clinical decision made by the registered nurse in partnership with the GP. The GP completes the verification section on the specific consent verifying or not verifying the use of restraint. The family will be involved in as many aspects of the decision as possible, and their input recorded on the assessment form and in the progress notes by the RN. Family were not permitted to request restraint to be used unless there is clinical indication that supports the request. On the days of audit there were five hospital level residents with bedrail restraint and two hospital level resident with and enabler (one bedrail and one lap belt).
Standard 2.2.1: Restraint approval and processes 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.	FA	The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator (care home manager) and for staff are documented and understood. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements. Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint. Restraint authorisation is in consultation/partnership with the resident, family and the GP. The use of restraint is linked to the resident's restraint care plan, evidenced in the residents' files reviewed. An internal restraint audit, conducted six-monthly, monitors staff compliance in following restraint procedures. Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Consistent evidence to verify one and two hourly checks were evidenced on the monitoring forms for the two residents' files used where restraint was in use. A restraint register is in place providing an auditable record of restraint use and is completed for residents requiring restraints and enablers.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is	FA	A restraint assessment tool is completed for residents requiring an approved restraint for safety. Assessments are undertaken by the restraint coordinator in partnership with the RNs, GP, resident and their family/whānau. Restraint assessments are based on information in the care plan, resident/family

undertaken, where indicated, in relation to use of restraint.		discussions and observations. Ongoing consultation with the resident and family/whānau are evident. The file for two hospital level residents using restraint and one hospital level resident using an enabler were reviewed. The completed assessment considered those listed in 2.2.2.1 (a) - (h). A restraint register is in place providing an auditable record of restraint use and is completed for residents requiring restraints and enablers.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint. Restraint authorisation is in consultation/partnership with the resident, family and the GP. The use of restraint is linked to the resident's restraint care plan, evidenced in the residents' files reviewed. An internal restraint audit, conducted six-monthly, monitors staff compliance in following restraint procedures. Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Consistent evidence to verify one and two hourly checks were evidenced on the monitoring forms for the two residents' files used where restraint was in use. A restraint register is in place providing an auditable record of restraint use and is completed for residents requiring restraints and enablers.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations are conducted three-monthly and include family, evidenced in two residents' files where restraint was in use. The restraint coordinator reported that restraint use is also discussed monthly in the registered nurse meeting. This was confirmed in the meeting minutes. The restraint minimisation programme is discussed and reviewed at a national level and includes identifying trends in restraint use, reviewing restraint minimisation policies and procedures and reviewing the staff education and training programme.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review	FA	The restraint minimisation programme is discussed and reviewed at a national level and includes identifying trends in restraint use, reviewing restraint minimisation policies and procedures and reviewing the staff education and training programme.

of their use of restraint.		

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired	PA Moderate	There are a number of monitoring forms and charts available for use including bowel charts, blood pressure, temperature, weight, blood sugar levels (paper-based), fluid balance charts, food and fluid chart, IOWA pain monitoring and neurological observations, however the repositioning charts for one resident with a pressure injury had not been fully completed. Short-term care plans describe interventions required to support long-term resident needs for changes to health status, but there was no short-term care plan in place for one resident with unintentional weight loss. There was no medical information available for two residents under other DHB contracts.	(i) The repositioning chart for one hospital resident (under the CMI contract) with a pressure injury, had not been completed at the required intervals as identified in the support plan. (ii) There were no documented or implemented interventions for one rest home resident of low body weight with continuing unintentional weight loss. (iii) There was no medical information available on the resident file from the GP/NP or other allied health professional for the respite care and oncology resident.	(i) Ensure monitoring is completed where needed. (ii) Ensure interventions are documented and implemented for changes to resident health status. (iii) Ensure medical information is available for short-term residents.

outcomes.				90 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	CI	The residents had been asking for a home puppy for quite some time, however the service was cautious due to some residents with pet allergies and immunocompromised conditions. The service researched a breed of dog that would be compatible with the residents and just over year ago two puppies became part of the	The service researched information on particular breeds of dogs that had hypoallergenic fur coats, were calm and small enough for residents to handle. Letters and photos of two chosen puppies went out to residents and families regarding a proposal for daily pet therapy with the puppies on site. Consent was obtained from residents who chose to participate in activities with the puppies and families consented on behalf of residents who were not able to do so. The office manager (now the village manager) and the clinical manager (now retired) both got a cavalier poodle each. During the day the puppies came into the home with their owners and the residents became involved in the puppies’ care and were kept informed on vet care. Residents enjoyed watching the puppies grow and involved them in events and celebrations held in the home. One-on-one time with the puppies was enjoyed with residents. Families would request the puppies be present when they were visiting as they brought joy to the resident. The residents organised a first birthday and meatloaf birthday cake for the puppies. There are weekly records of puppy interactions with residents and many photographs displayed that evidence the residents joy in having their home puppies. Many emails were sighted from family members who expressed how happy their relative was with having pets to love like their own. The retired clinical manager still brings in her puppy weekly to see the residents.

		Summerhill family. The DT has introduced sensory stimulation therapy (SST) with activities that encourage residents with dementia to communicate and engage with staff, families and other residents. Feedback from families and photographs viewed demonstrated the success of SST.	Sensory stimulation therapy (SST) is the activation of one or more of the senses of taste, vision, hearing, touch and smell and encourages residents with memory loss to remember positive memories and emotions. Included in the programme is music, hand massage, aromatherapy, pet therapy, Inmu therapy, sensory garden and individual memory boxes. Newsletters went out to families informing them of the benefits of SST and asking families to contribute towards their relative memory box. The DT met with families and showed them a sample memory box. An example of a memory box viewed was for a resident who had been a hairdresser and contained a model hairdryer and a bottle of their favourite perfume. The benefits of SST are known to reduce agitation, improve mental wellbeing and used as a non-pharmacological intervention for anxiety, depression and behaviours of concern. Verbal positive feedback from families have been received through the six-monthly MDT meetings. Survey results on the activities provided have improved from 3.7 in 2019 to 4.5 in 2020 (with 5 being the highest).

End of the report.