

# Summerset Care Limited - Summerset at Karaka

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## Introduction

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

The audit has been conducted by 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:

<b>Legal entity:</b>	Summerset Care Limited
<b>Premises audited:</b>	Summerset at Karaka
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 15 July 2021    End date: 16 July 2021
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	52

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Summerset at Karaka provides rest home and hospital level care for up to 50 residents in the care centre and up to 20 rest home residents in the serviced apartments. On the day of the audit there were 49 residents in the care centre and three rest home residents in the serviced apartments.

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

The service is managed by a village manager who has been in the role 18 months and a care centre manager (registered nurse) who has been in the role for two years. The management team is supported by a regional team with the regional quality manager supporting the audit process.

The service has a documented quality and risk management programme that is well implemented. Improvements since the last audit have been an emphasis on ensuring that neurological observations are completed when required and to handovers. The residents and relatives interviewed spoke very positively about the care and support provided.

This audit identified a shortfall around performance appraisals.

## 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.
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Summerset at Karaka 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.		Some standards applicable to this service partially attained and of low risk.
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Summerset at Karaka has a quality and risk management system in place. Key components of the quality management system link to a number of meetings including monthly quality improvement meetings. 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 with allocation of staffing that meets acuity and numbers of residents.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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The registered nurses are responsible for each stage of service provision. Residents' records reviewed provided evidence that the registered nurses utilise the interRAI assessment to assess, plan and evaluate care needs of the residents. These are then reviewed and discussed with the resident and/or family/whānau input. Care plans viewed demonstrate service integration and are reviewed at least six-monthly. Resident files include medical notes by the contracted general practitioner (GP), and visiting allied health professionals.

All staff responsible for the administration of medicines complete education and medication competencies. The electronic medication charts (Medimap) are reviewed at least three-monthly by the general practitioner.

The recreational therapists implement the activity programme to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and themed celebrations. Residents and families reported satisfaction with the activities programme.

All meals are cooked on site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. There are nutritious snacks available at all times. An external dietitian reviews the menu plans of the outsourced caterer.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building holds a current building warrant of fitness. All internal and external areas are safe and well maintained. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Chemicals are stored securely throughout the facility. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances. Electrical equipment has been tested and tagged. All medical equipment and all hoists have been serviced and calibrated (where applicable).

Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. Cleaning and laundry services are well monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies are provided. There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency. There is an approved evacuation scheme and emergency supplies for at least three days. At least one first aid trained staff member is on duty at all times.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort. Residents did not use any restraints on the days of audit. Eleven residents used some devices identified as enablers. Each resident was able to give consent for the use of the enabler.

## Infection prevention and control

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

Standards applicable to this service fully attained.

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator is responsible for coordinating education and training for staff. The infection control coordinator has completed annual training provided by Summerset head office and online MOH training. There is a suite of infection control policies and guidelines available electronically to support practice. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. The service engages in benchmarking with other Summerset facilities. There have been no outbreaks since the previous audit.

## 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)
<b>Standards</b>	0	44	0	1	0	0	0
<b>Criteria</b>	0	92	0	1	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0



# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<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 were held with three managers (the village manager, the regional quality manager, and the care centre manager [CCM]). Interviews also took place with four caregivers, four registered nurses (RNs), two clinical leaders, one kitchen manager, one maintenance, two recreational therapists, one national diversional therapist, one cleaner and one office administrator. All confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). All staff complete training around the Code with this being last provided in 2021. Observation during the audit confirmed this in practice.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. Written general and specific consents were sighted in the eight resident files reviewed (three rest home and five hospital). Caregivers and registered nurses (RNs) interviewed, confirmed verbal consent is obtained when delivering care.</p> <p>Resuscitation orders are appropriately signed by the resident and general practitioner. The service acknowledges the resident is for resuscitation in the absence of a signed directive by the resident. The general practitioner (GP) discusses resuscitation with families/enduring power of attorney (EPOA) where the resident is deemed incompetent to make a decision. Discussion with family members identified that the</p>

consent.		<p>service actively involves them in decisions that affect their relative's lives.</p> <p>Eight resident files of long-term residents have signed admission agreements.</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 in the care centre. The Code and advocacy is discussed with residents and relatives on admission to the service.</p> <p>An independent advocate attends the service mainly for the village but is available at any time for residents or family. The service provides opportunities for the family/enduring power of attorney (EPOA) to be involved in decisions as evidenced in the resident files reviewed. The resident files include information on residents' family/whānau and chosen social networks.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	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 cafés and restaurants. Interviews with staff, residents and relatives confirmed that residents are supported and encouraged to remain involved in the community and external groups. Relative and friends are encouraged to be involved with the service and provision of 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 service has a complaints policy that describes the management of complaints. There are feedback forms available with a suggestion box at reception that is cleared at least weekly by the CCM. Information about complaints is provided on admission. Interview with residents and families demonstrated an understanding of the complaints process. All staff interviewed could describe the process around reporting complaints.</p> <p>There is a complaint register. Verbal and written complaints are documented. There have been three complaints in 2020 and one complaint year to date. The documentation including the responses to three complaints noted that the complaint was informed that the complaint had been received within five days, investigation, corrective actions when required, and resolutions in place if required. Each complainant was met with after the investigation had been completed and all complainants were recorded as being satisfied with the outcome.</p> <p>There were no complaints lodged by any external provider since the last audit.</p>

		Discussions with residents and families confirmed that their issues are addressed, and they feel comfortable to bring up any concerns. No family or residents interviewed had any complaints.
<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 potential resident and to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Thirteen residents (nine requiring hospital level of care and four at rest home level of care including two in the serviced apartments) and five relatives (four hospital and one rest home) interviewed, identified they are well informed about the Code. The Code (in English and Māori) are displayed at the main entrance of the care centre. There are opportunities for residents and relatives to provide feedback and discuss issues including through the resident/family meetings and the through the annual residents'/relatives' survey.</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. The managers and staff encourage each resident to engage with their own spiritual support and there were examples of residents who chose to meet with church or spiritual groups in the whānau room. The CCM described contacts with mainstream and other religious organisations in the community and noted that if residents wished to meet with any, then this would be arranged.</p> <p>Resident files include cultural and spiritual values. 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 abuse and neglect policy. Staff receive education and training on abuse and neglect (last completed in 2021). There were no incidents of abuse or neglect recorded in the past year. Staff were able to describe the process of escalating any concerns and managers described the process of managing these.</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</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.</p> <p>Links are established with a local iwi through a staff member who identifies with Māori and the area. If there is a specific need to engage with kaumātua or kuia, then the staff member can organise this. This includes blessings of rooms if required. The service also has access to advisors at the Māori health unit at the DHB.</p>

and cultural, values and beliefs.		There were no residents who identified as Māori on the day of audit. Staff interviewed were able to describe how they would ensure they meet the cultural needs of residents identifying as Māori. Treaty of Waitangi and cultural safety is included in the education planner and was last provided in 2021.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	An initial care planning meeting is carried out where the resident and/or whānau as appropriate/able are invited to be involved. Individual beliefs or values are further discussed and incorporated into the care plan. Six monthly multi-disciplinary team meetings occur to assess if needs are being met. Family are invited to attend. Discussion with relatives confirmed values and beliefs are considered. Residents interviewed confirmed that staff consider their culture and values.
Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Staff job descriptions include responsibilities and staff sign a copy on employment. House rules and a code of conduct are included in the employment contract and staff sign a professional boundaries policy on employment. The staff and clinical meetings occur monthly and include discussions on professional boundaries and concerns as they arise. Management provide guidelines and mentoring for specific situations.  Interviews with the village manager, CCM and clinical nurse leaders confirmed an awareness of professional boundaries. Caregivers and RNs interviewed were knowledgeable around the scope of their role and responsibilities. The registered nurses supervise staff to ensure professional practice is maintained in the service.
Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard.	FA	All Summerset facilities have a master copy of policies which have been developed in line with current accepted best practice and are reviewed regularly. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff. There is a quality improvement programme that includes performance monitoring against clinical indicators and benchmarking against like services within the group is undertaken. There is a culture of ongoing staff development with an in-service programme implemented in 2020 and 2021.  There is an embedded quality and risk management programme. Registered nurses are also given a shared portfolio to manage, and this ensures that there is a focus on KPIs (e.g., falls prevention, infection control restraint, wound management, continence, medication management, or manual handling).

		<p>There is good liaison and working relationship with the DHB personnel and outside organisations such as Hospice. There are implemented competencies for caregivers and registered nurses specific to their roles.</p> <p>Residents interviewed spoke very positively about the care and support provided and stated the management team are very approachable.</p> <p>Staff interviewed had a sound understanding of principles of aged care and stated that they feel supported by the management team. They also stated that they work as a team and there are no issues with staffing. Teamwork was observed during the audit.</p>
<p>Standard 1.1.9: Communication</p> <p>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 26 accident/incidents reviewed on the electronic register. Resident/relative meetings are held monthly and there are friends and family meetings quarterly. The village manager and the CCM have an open-door policy. Family were kept informed during the pandemic with information given around Covid-19 and expectations (e.g., around visiting). Residents stated that they were also kept well informed.</p> <p>Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The service has policies and procedures available for access to interpreter services for residents (and their family/whānau). If residents or family/whānau have difficulty with written or spoken English, the DHB interpreter services are made available.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The service provides care for up to 50 residents at hospital and rest home level care in the care centre, and up to 20 rest home level of care residents in serviced apartments. On the day of the audit, there were 49 residents in the care centre with two at rest home level and 47 hospital level residents. There were a further three residents at rest home level of care in the serviced apartments. All residents were under the Age-Related Residential Care Contract. There were no residents using respite care or aged under 65 years. All beds in the care centre are dual-purpose beds.</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 at Karaka has a site-specific business plan and goals that are developed in consultation with the village manager, CCM and regional quality manager who was present to provide support during the audit. The Summerset at Karaka quality plan is reviewed quarterly throughout the year with the current plan documented in 2021.</p> <p>The village manager (non-clinical) has been in the role at Summerset at Karaka for 18 months and has also had five years' experience as a village manager at another aged care facility. The village manager is</p>

		<p>supported by a care centre manager/registered nurse who has 16 years' experience in aged care with two years in the current role. There are also two clinical nurse leaders who provide additional leadership for the registered nurses and other care staff. One clinical nurse leader has 10 years' experience in aged care and the other has two years' experience and started in the role in February 2021.</p> <p>There are weekly meetings with the regional quality manager. All managers have at least eight hours education in relevant fields per year.</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>	FA	<p>The CCM provides support for the service along with the regional quality manager and other head office staff if the village manager is on leave. The clinical nurse leaders provide clinical oversight along with support from head office if the CCM is on leave. The regional quality manager provides oversight and support at any time.</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>	FA	<p>Summerset at Karaka is implementing an organisational quality and risk management system. Interviews with managers and staff reflected their understanding of the quality and risk management systems that have been put into place.</p> <p>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.</p> <p>The Summerset group has schedules of training and audit requirements for the month/year. The village manager and CCM complete monthly reports confirming completion of requirements. Quality management systems are linked to internal audits, incident and accident reporting, health and safety reporting, infection control data and complaints management. Data is collected from VCare surveys, audits, and review of key performance indicators (KPIs). There are monthly accident/incident benchmarking reports completed by the CCM that break down the data collected across the rest home and hospital. Infection control is also included as part of benchmarking across the organisation. Data is analysed and corrective actions are required based on benchmarking outcomes. The regional quality manager is alerted automatically through the system of any high-level accident/incidents (resident, staff and environmental). Data is analysed and the results discussed at a variety of meetings including monthly staff, clinical (registered nurse), health and</p>

		<p>safety and other portfolio meetings such as for infection control and medication management. Corrective action plans are documented with evidence of resolution of issues in a timely manner.</p> <p>A number of quality improvements have been made since the last audit. These have focused for example, on improving the handover process, involvement of the CCM in the steering group for the national roll out of the person-centred care model and improving palliative care services.</p> <p>An annual residents/relatives survey has been completed in 2020 with this reporting a 98% satisfaction rate. The 2021 survey is due to be held later in the year. The promoter score was 76.5 out of 100. The results have been communicated to residents and staff.</p> <p>There is a health and safety and risk management programme in place including policies to guide practice and minimise risk. The service has health and safety officers who attend the health and safety meeting. They also serve to take issues to the committee on behalf of staff and bring back information from management after discussion. Staff interviewed confirmed they are informed when health and safety meetings are due and have the opportunity to provide input into health and safety. Each month there is a focus on one of the golden rules of safety. All staff and contractors receive a health and safety induction. The hazard register has been updated annually.</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.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>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>Incident and accident data has been collected and analysed. Of the 26 resident related incident reports that were reviewed, 20 were for unwitnessed falls or when a resident had hit their head. The service has focused on recording neurological observations as per policy on those residents who had an unwitnessed falls or had hit their head and all included observations as per the policy. Appropriate recordings, short term care plans and other interventions were in place for residents when there had been a skin tear, challenging behaviour, bruise, or a wound as sighted in six other incident forms reviewed. All reports and corresponding resident files confirmed that family were notified of any incident.</p> <p>Discussions with the village manager and CCM confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have not been any section 31 notifications required to have been lodged with the MOH and DHB since the last audit. There have been no outbreaks to report.</p>

<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Low</p>	<p>There are human resources policies to support recruitment practices. A list of RN and allied health practising certificates is maintained.</p> <p>Eight staff files (one care centre manager, two clinical nurse leaders, two RNs, three caregivers) were reviewed and all had relevant documentation relating to employment. All files included a signed contract, reference checks, a police check, and job description. Not all performance appraisals had been completed annually.</p> <p>The service has an orientation programme in place for each role that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and one new staff member stated that they were supported through a buddy staff member and fully orientated to the service. Caregivers are encouraged to start level two of Careerforce once they have completed their orientation booklet or six months post start date. There is an annual education plan that is implemented for 2021. Attendance records showed high levels of staff attendance. The training programme is flexible enough to add additional in-services relevant to the service. External education is also provided, and RNs are linked to the PDRP (professional development recognition programme) at the DHB.</p> <p>There are nine registered nurses at Summerset at Karaka with six interRAI trained as well as the clinical nurse leaders who have also completed interRAI training. The following numbers of caregivers have completed Careerforce training: six at level two; 10 at level three; and 14 at level four.</p> <p>A competency programme is in place with different requirements according to work type (e.g., caregivers, registered nurse, and kitchen). Core competencies are completed, and a record of completion is maintained on staff files and online. The contracted physiotherapist completes safe manual handling and hoist training for staff.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The village manager and care centre manager work 40 hours per week (Monday to Friday). There are two clinical nurse leaders. One works three days a week (Tuesday, Wednesday, and Thursday) and the other works on the other four days a week. The second one works Fri, Sat sun Mon. The CCM and clinical nurse leaders take a week on call with the CCM and village manager available at any time.</p> <p>There is a caregiver allocated to provide care for serviced apartment clients in the morning (7 am to 3 pm); a caregiver on from 7.30 am to 12 pm; a caregiver from 3 pm to 11 pm; and a staff in the care centre are allocated to provide support and to check on residents in the serviced apartments at rest home level overnight.</p> <p>The care centre is staffed as follows: nine caregivers on the morning shift (six on a full shift, one from 7 am to 11 am, and two from 7 am to 1 pm); seven caregivers on the afternoon shift including four full shift, two from 4 pm to 9 pm and one from 5.30 pm to 7.30 pm (monitoring and support for residents in the lounge);</p>



		<p>and two caregivers overnight.</p> <p>There are two registered nurses on each shift (morning, afternoon, and night shifts) as well as the CCM and clinical nurse leaders during the day. One caregiver with a first aid certificate is allocated to attend emergency calls in the village on each shift.</p> <p>Staffing levels and skills mix policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery. Relatives and residents confirmed there were always sufficient staff on duty. They also described the registered nurses and managers as being very supportive and able to provide assistance at any time.</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 are electronically documented and 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 electronic 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>There is an implemented Summerset admission policy and procedures to safely guide service provision and entry to the service. 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. The service has an information pack available for residents/families/whānau at entry. The admission information pack outlines access, assessment and the entry screening process. The service operates twenty-four hours a day, seven days a week. Comprehensive information about the service is made available to referrers, potential residents and their families. Resident agreements contain all detail required under the ARCC. The eight admission agreements reviewed meet the requirements of the ARCC and were signed and dated. Exclusions from the service are included in the admission agreement.</p> <p>Family members and residents interviewed stated that they have received the information pack and have received sufficient information prior to and on entry to the service. Family members reported that the care centre manager or clinical nurse leaders are available to answer any questions regarding the admission process.</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>	<p>FA</p>	<p>The service has a policy that describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident's electronic file. All relevant information is documented and communicated to the receiving health provider or service. Transfer notes and discharge information was available in resident records of those with previous hospital admissions. One file reviewed was of a resident who had been transferred to hospital to investigate pyrexia with unknown cause (unable to take paracetamol). All appropriate documentation and communication were completed. Transfer to the hospital and back to the facility post-discharge was well documented. Communication with family was made in a timely manner.</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>	<p>FA</p>	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There was one resident self-administering on the day of audit. The resident had a current assessment and safe storage of their medication within their room. All legal and policy requirements had been met. There are no standing orders in use. There are no vaccines stored on site. All clinical staff who administer and/or countersign for medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Registered nurses have completed syringe driver training. Staff were observed to be safely administering medications.</p> <p>Registered nurses interviewed could describe their role regarding medication administration. All medications are checked on delivery against the electronic medication chart and any discrepancies are fed back to the supplying pharmacy. Medications were appropriately stored in the facility medication room. The medication fridge and medication room temperatures are monitored daily, and the temperatures were within acceptable ranges. All medications including the bulk supply order are checked weekly. All eyedrops have been dated on opening.</p> <p>Staff sign for the administration of medications electronically. Sixteen electronic medication charts were reviewed. The medication charts reviewed identified that the GP had reviewed all resident medication charts three monthly. Each drug chart has a photo identification and allergy status identified. 'As required' medications had indications for use charted.</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</p>	<p>FA</p>	<p>The meals at Summerset Karaka are all prepared and cooked on site. The kitchen was observed to be clean, well-organised and a current approved food control plan was in evidence. There is a four-weekly seasonal menu that is designed and reviewed by a registered dietitian at an organisational level for the outsourced caterers. The kitchen manager receives resident dietary information from the RNs and is notified of any changes to dietary requirements (vegetarian, pureed foods) or of any residents with weight loss. The head chef (interviewed) is aware of resident likes, dislikes and special dietary requirements. Alternative meals are offered for those residents with dislikes or religious preferences. Residents have</p>

<p>a component of service delivery.</p>		<p>access to nutritious snacks 24 hours a day. On the day of audit, meals were observed to be well presented.</p> <p>Kitchen fridge and freezer temperatures are monitored and recorded daily. Food temperatures are checked at all meals. These are all within safe limits. Staff were observed wearing correct personal protective clothing in the kitchen and in the serveries. Cleaning schedules are maintained.</p> <p>There is one dining room on the care centre. Meals are delivered in hot boxes and served from satellite kitchen in care centre. Staff were observed assisting residents with meals in the dining room and modified utensils are available for residents to maintain independence with meals. Food services staff have all completed food safety and hygiene courses. The food control plan expires 27 February 2022.</p> <p>The residents interviewed were very satisfied with the standard of food service and the variety and choice of meals provided. They are able to offer feedback on a one-to-one basis to the head chef who makes a point of interacting with residents in the dining areas, at the resident meetings and through resident surveys.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>The service records the reason for declining service entry to potential residents should this occur and communicates this to the consumer and where appropriate their family/whānau member of choice. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. The initial support plan is developed by the registered nurses with information from the initial assessment and information provided from discharge summaries, allied health professionals and in consultation with the resident/relatives.</p> <p>The service uses assessments on the electronic resident management system and interRAI assessments for all residents. These are completed on admission and reviewed six-monthly as part of the evaluation unless changes occur prior, in which case a review is carried out at that time. InterRAI assessments had been completed for all long-term residents' files reviewed. These were within timeframes and areas triggered were addressed in the care plans sampled.</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Eight resident files were reviewed across a range of conditions including (but not limited to) recurrent falls, diabetes, behaviour that challenge, and catheter care. In all files reviewed the care plans were comprehensive, addressed the resident need and were integrated with other allied health services involved in resident care. Service integration was evidenced by documented input from a range of specialist care professionals, including the podiatrist, dietitian, vascular specialist and mental health care team for older people. Relatives and residents interviewed all stated they were involved in the planning of resident care. In all files reviewed there was evidence of resident and relative involvement in care planning.</p> <p>Activity assessments were completed by the activities staff within three weeks of admission. Care plans reviewed provided evidence of individualised support. Short-term care plans are in use for short-term needs and changes in health status. The care staff interviewed advised that the care plans were easy to follow. Integration of records and monitoring documents are well managed.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>The registered nurses complete care plans for residents. Progress notes in all files reviewed had details which reflected the interventions documented in the long-term care plans. When a resident's condition alters, the registered nurse initiates a review and if required, GP or specialist consultation. Short-term care plans are documented for changes in health status. Staff stated that they notify family members about any changes in their relative's health status, and this was confirmed by family members interviewed. Family members interviewed stated they are notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. Evidence of relative contact for any changes to resident health status was viewed in the resident files sampled. Care plans reviewed documented sufficient detail to guide care staff in the provision of care. A physiotherapist is contracted to assess and assist residents' mobility and transfer needs as required.</p> <p>Wound assessment, appropriate wound management and ongoing evaluations are in place for all wounds. Wound monitoring occurred as planned and is documented on both a paper based wound log and the electronic system. Ongoing wounds included fourteen skin tears, six surgical wounds, two chronic wounds, two blisters and abrasion. There was evidence of wound nurse specialist involvement in chronic wound management. The facility wound champion facilitates the pressure injury prevention and management programme. There were no pressure injuries at the time of audit.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the RNs interviewed. Care staff stated there are adequate clinical supplies and equipment provided, including continence and wound care supplies, and these were sighted on day of audit.</p> <p>Monitoring charts sighted included (but are not limited to), vital signs, blood glucose, pain, food and fluid,</p>

		<p>turning charts, neurological observations, bowel monitoring and behaviour monitoring. All monitoring requirements including neurological observations had been documented as required.</p> <p>Care plans have been updated as residents' needs changed. The GP interviewed was very complimentary of the service and care provided.</p>
<p><b>Standard 1.3.7: Planned Activities</b></p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The service employs two diversional therapists covering Monday to Sunday between them, who plan and lead the activities in the home. One is a qualified diversional therapist (DT) with the other currently towards the DT qualification. There are set Summerset activities including themes and events which the activities team add to in order to individualise activities to resident need and preferences. A weekly activities calendar is distributed to residents, posted on noticeboards and is available in large print. On the days of audit residents were observed participating in activities. The recreational therapist seeks verbal feedback on activities from residents and families to evaluate the effectiveness of the activity programme, enabling further adaptation if required. Residents interviewed were positive about the activity programme.</p> <p>Residents are able to participate in a range of activities that are appropriate to their cognitive and physical capabilities. There are weekly outings to places chosen by the residents and there are regular entertainers visiting the facility. Special events like birthdays, Easter, Mothers' Day, Anzac Day and other cultural festive days are celebrated. There are visiting community groups such as local church groups, a ukulele group and pet therapy. The activity team provide a range of activities which include (but are not limited to) men's club, balance exercises, crafts, games, quizzes, entertainers, happy hour and bingo.</p> <p>The activity team are involved in the admission process, completing the initial activities assessment, and have input into the cultural assessment. An activities plan is completed within timeframes, a monthly record of attendance is maintained, and evaluations are completed six-monthly.</p> <p>Those residents who prefer to not to participate in communal activities receive one-on-one visits and individualised activities such as pampering sessions according to their preferences. The service also uses Inmu (interactive music therapy) devices for anxious and/or cognitively challenged residents.</p>
<p><b>Standard 1.3.8: Evaluation</b></p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Six of the eight resident care plans reviewed had been evaluated by the registered nurses six-monthly or earlier if there was a change in health status. One hospital and one rest home resident had not been in the service for six months at the time of audit. There is evidence of resident and family involvement in the review of long-term resident care plans against resident goals.</p> <p>Activities plans are in place for each of the residents and these are also evaluated six-monthly. There are three-monthly reviews by the GP for all residents which family are able to attend if they wish to do so. Six monthly multi-disciplinary reviews and meeting minutes are completed by the registered nurse with input</p>

		from caregivers, the GP, the recreational therapists, resident and family/whānau members and any other relevant person involved in the care of the resident. The contracted GP reviews the resident at least three-monthly. Short-term care plans are in use for acute and short-term issues. These are evaluated at regular intervals.
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Summerset Karaka facilitates access to other medical and non-medical services. Referral to other health and disability services is evident in the sample group of resident files. The RNs initiate referrals to nurse specialists, and allied health services. Other specialist referrals are made by the GP. Referrals and options for care were discussed with the family, as evidenced in medical notes. Referral documentation is maintained on resident files. The registered nurse interviewed gave examples of where a resident's condition had changed, and the resident care plan had been changed to reflect updated interventions accordingly. Discussion with the registered nurses identified that the service has access to a wide range of support either through the GP, specialists, and allied health services as required.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>There are policies and documented processes regarding chemical safety and waste disposal in place. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas. Safety datasheets and product sheets are available and readily accessible for staff. Sharp's containers are available and meet the hazardous substances regulations for containers. The hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff and were seen to be worn by staff when carrying out their duties on the day of audit. A spills kit is available.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building holds a current building warrant of fitness, which expires on 8 October 2021. Request forms for repairs are available for residents and staff, these then being entered on to the 'Tech1' property management system and signed off electronically as repairs are completed. There is a full-time property manager who, with the property team, carries out the 52-week planned maintenance programme. The property manager is also on call after hours for urgent matters. The checking and calibration of medical equipment including hoists, has been completed annually and is next due June 2022. All electrical equipment has been tested and tagged, and hot water temperatures have been tested and recorded monthly with corrective actions for temperatures outside of the acceptable range. Preferred contractors are</p>

		<p>available 24/7.</p> <p>The corridors are wide and promote safe mobility with the use of mobility aids and transferring equipment. Residents were observed moving freely around the areas with mobility aids, where required. There is outdoor furniture and seating with shade in place, and there is safe access to all communal areas. The external areas have landscaped formal gardens with wide wheelchair accessible paths.</p> <p>The caregivers and RNs interviewed stated that 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>All bedrooms apart from seven have ensuites. The seven share communal facilities bathrooms located adjacent to the rooms. Visual inspection evidenced toilet and shower facilities are of an appropriate design to meet the needs of the residents and there is ample space in toilet and shower areas to accommodate shower chairs and a hoist if required. There are adequate numbers of communal toilets located near the communal areas. Communal toilet/shower facilities have a system that indicates if it is engaged or vacant.</p> <p>Fixtures, fittings, floorings and wall coverings are in good condition and are made from materials which allow for ease of cleaning.</p> <p>Privacy curtains are in shower rooms. Residents interviewed reported their privacy is maintained at all times.</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>All resident rooms are spacious enough to safely manoeuvre mobility aids and transferring equipment such as hoists in the resident bedrooms. The doors are wide enough for ambulance trolley access. Staff interviewed reported that they have more than adequate space to provide care to residents.</p> <p>Residents are encouraged to personalise their bedrooms with personal belongings 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</p>	FA	<p>There are numerous spacious communal areas throughout the facility. Activities as observed on the day of the audit are held in the lounges. The lounges are large enough so there is no impact on other residents who are not involved in activities. The arrangement of seating and space allows both individual and group activities to occur. There were smaller lounges/family rooms, equipped with a kitchenette where residents who prefer quieter activities or family/visitors may sit and make a cup of tea/coffee. The dining rooms are spacious.</p>

areas to meet their relaxation, activity, and dining needs.		
<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>The service has a comprehensive cleaning and laundry manual to guide staff in the safe and efficient use of laundry and cleaning services. Cleaning and laundry services are monitored through the internal auditing system. Safety data sheets are available in both the laundry and cleaners' rooms. There is a locked chemical storage area located in the laundry. There is appropriate personal protective wear readily available. There are dedicated laundry staff and cleaners on duty seven days a week. All laundry is undertaken on site.</p> <p>The laundry is spacious and well organised and divided into a 'dirty and clean' area with a defined work flow. The laundry is located on the ground floor and clean laundry is transported in covered trolleys by lift to the care centre.</p> <p>Cleaning trolleys sighted were well equipped and are kept in designated locked areas when not in use. There are locked chemical boxes securely fixed to the cleaning trolley.</p> <p>Sluice rooms were kept locked when not in use. Residents and family interviewed reported satisfaction with the cleaning and laundry service.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>There is an emergency and civil defence plan to guide staff in managing emergencies and disasters. Emergencies and first aid are included in the mandatory in-service programme. There is a first aid trained staff member on every shift. Summerset Karaka has an approved fire evacuation plan and fire drills occur six-monthly. Smoke alarms, sprinkler system and exit signs are in place. The service has alternative cooking facilities (barbeque) available in the event of a power failure. There is a large external water storage tank and stored bottled water for use in an emergency. The service holds at least three days of food storage. Emergency power is used for lighting and calls bells for up to two hours with torches readily available. A generator is able to be accessed if necessary.</p> <p>Call bells were evident in resident's rooms, lounge areas, and toilets/bathrooms.</p> <p>The facility is secured at night. The village gates are locked at night with access to the emergency services. There are security cameras at entry and exit points.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with</p>	FA	<p>All bedrooms and communal areas are appropriately heated, have ample natural light and ventilation. The facility utilises a combination of reticulated hot air heating and panel heaters, all of which are thermostatically controlled. Staff and residents interviewed stated that these are effective. All bedrooms and communal areas have at least one external window. There is a monitored outdoor area where</p>



adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.		residents may smoke. All other areas are smoke free.
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Staff are well-informed about infection control practises and reporting. The infection control coordinator (ICC) is an RN who is responsible for infection control across the facility as detailed in the ICC job description (signed copy sighted on day of audit). The ICC oversees infection control for the facility, reviews incidents on the electronic system and is responsible for the collation of monthly infection events and reports. The infection control committee and Summerset head office are responsible for the development and review of the infection control programme.</p> <p>Hand sanitisers are appropriately placed throughout the facility. All sinks have single use hand towels and pump soap available. Visitors are asked not to visit if they are unwell. All residents apart from four have received two doses of the Pfizer Covid-19 vaccine, 100% of staff have received the first dose, with 70% having received their second dose of vaccine.</p> <p>The facility has a Covid/Pandemic plan in place and appropriate amounts of PPE on hand to last for at least two weeks in case of a further lockdown. During Covid the service held regular virtual meetings with the DHB Covid preparedness team to check policies, procedures and service readiness. As part of the pandemic response the service implemented mandatory staff and resident temperature checking (from level 2). Plans are available to cohort staff if required and resident isolation procedures are available. Covid scanning and/or manual sign in is mandatory. Covid-19 education has been provided for all staff, including hand hygiene, donning and doffing, and use of PPE.</p> <p>Residents are offered the influenza vaccine annually. There have been no outbreaks since the last audit.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the</p>	FA	<p>There are adequate resources to implement the infection control programme at Summerset Karaka. The ICC liaises with the infection control committee who meet monthly and as required (more frequently in case of Covid level change). Information is shared as part of staff meetings and also as part of the registered nurse meetings. The ICC has completed annual training in infection control. External resources and support are available through the Summerset regional quality manager, external specialists, microbiologist, GP, wound nurse and DHB when required. The GP monitors the use of antibiotics. Overall effectiveness of the programme is monitored by Summerset head office.</p>

organisation.		
<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>	FA	<p>The infection control policies include a comprehensive range of standards and guidelines including defined roles and responsibilities for the prevention of infection, the infection control team, and training and education of staff. Infection control procedures developed in respect of care, the kitchen, laundry and housekeeping incorporate the principles of infection control. Policies are updated regularly and directed from Summerset head office.</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>	FA	<p>The ICC is responsible for coordinating/providing education and training to staff. The orientation package includes specific training around hand hygiene and standard precautions. Annual infection control training is included in the mandatory in-services that are held for all staff, and staff have completed infection control education in the last 12 months. The infection control coordinator has access to the Summerset ILearn intranet with resources, guidelines best practice, education packages and group benchmarking. The ICC has also completed infection control audits.</p> <p>Resident education occurs as part of providing daily cares and as applicable at resident meetings.</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>	FA	<p>Surveillance is an integral part of the infection control programme, and the purpose and methodology are described in the Summerset surveillance policy. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility.</p> <p>Monthly infection data is collected for all infections based on standard definitions as described in the surveillance policy. Infection control data is monitored and evaluated monthly and annually. Trends are identified and analysed, and preventative measures put in place. These, along with outcomes and actions are discussed at the infection control meetings. Meeting minutes are available to staff.</p> <p>Infections are entered into the electronic database for benchmarking. Corrective actions are established</p>

		<p>where trends are identified.</p> <p>Systems in place are appropriate to the size and complexity of the facility.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service has policies and procedures to support of the use of enablers and restraints. The policy meets the intent of the restraint minimisation standards. One of the clinical nurse leaders is designated as the restraint coordinator. They have been in the role for over a year. They have a job description which defines the responsibilities of the role.</p> <p>There is no use of restraint in the service. Eleven residents are identified as having enablers which include bedrails for two residents, bed levers or hoops and monkey bars to assist with movement when in bed. Two resident records were reviewed. Bedrails were used for both residents and one resident also used a bed lever. Both had a consent from signed by the resident indicating that the use of the devices was voluntary. An assessment of the use of the devices was completed with risks of the device identified. The use of the enabler/s was documented in the care plan. The use of any restraint or enabler is reviewed at three monthly intervals with the restraint coordinator stating that this is reviewed more frequently if required.</p> <p>Restraint minimisation, enabler training and training around management of challenging behaviour is provided annually. Audits of the use of any restraints or enablers occurs six-monthly.</p>

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	<p>There is an annual education plan. This is implemented and well attended. The training programme is flexible enough to add additional in-services relevant to the service. Staff have a review following employment, to monitor progress towards completing their orientation programme and identify any learning opportunities. An annual appraisal is expected to be completed thereafter. Eight staff files were reviewed. One was a new staff member who was not required to have a performance appraisal, three had completed a performance appraisal in the last year, and four had not completed an appraisal in the past year (one had last completed an appraisal in April 2020, two in May 2020, and one did not have one on file).</p>	<p>Annual appraisals had not been completed for four of the eight staff files reviewed.</p>	<p>Ensure performance appraisals are completed annually.</p> <p>180 days</p>

## Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display
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End of the report.