Sunflower Field Trading NZ Limited - Summerville Rest Home

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:	Sunflower Field Trading NZ Limited
Premises audited:	Summerville Rest Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 29 September 2021 End date: 29 September 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: 12

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

Summerville Rest Home provides rest home level care for up to 15 residents. On the day of the audit there were 12 residents.

This certification audit was conducted against the 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 the general practitioner and staff.

The managing director manages the business remotely and is supported by the non-clinical manager. The service is overseen by the manager who has been in the role for 28 years. She is supported by a part-time RN who has been in the role for three months. Residents and family members interviewed spoke positively of the services provided at Summerville Rest Home.

This certification audit identified areas for improvement relating to notification of incidents, meetings, education, timeframes, care plan interventions and reviews, activities, medication storage and first aid training.

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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

The staff at Summerville Rest Home ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and advocacy services is easily accessible to residents and families. Staff interviewed were familiar with processes to ensure informed consent. Complaint's policies and procedures meet requirements and residents, and families are aware of the complaints process.

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.

Summerville Rest Home has a documented quality and risk management programme. Quality data is collated for accident/incidents, infection control, internal audits, complaints, and surveys. There is a current business plan in place. There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The

service has an orientation programme that provides new staff with relevant information for safe work practice. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.

Residents are assessed prior to entry to the service and an initial assessment is completed upon admission. The registered nurse is responsible for care plan development with input from residents and family. Risk assessments and the interRAI assessments form the basis of long-term care plans. The general practitioner reviews all residents at least three-monthly. Relatives interviewed stated they were fully informed of any changes in resident condition. Six monthly reviews are performed.

Medications are administered in line with legislation and current regulations. General practitioners review medication charts three monthly.

Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met. A dietitian is available on referral.

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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

There is a current building warrant of fitness. Essential contractors are available 24 hours a day. Chemicals are stored in a locked storage cupboard. There are dedicated housekeeping staff. There is a designated laundry, which includes storage of cleaning and laundry chemicals. All laundry is laundered on site by care staff. Documented systems are in place for essential, emergency and security services. The facility has two lounge areas. The main lounge is open plan with a dining area and is adjacent to the kitchen. Residents' rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. Residents can and do bring in their own furnishings for their rooms. Furniture is appropriate to the setting and arranged to allow residents to mobilise. Communal living areas and resident rooms are appropriately heated and ventilated. Residents have access to natural light in their rooms and there is adequate external light in communal areas. External garden areas are available with suitable pathways, seating and shade provided.

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.

Summerville Rest Home has restraint minimisation and safe practice policies and procedures in place. There were no residents requiring the use of a restraint or enabler. The service is committed to maintaining a restraint-free environment.

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.

There is a suite of infection control policies and guidelines that meet infection control standards which include policies and procedures around Covid-19. The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The registered nurse is the infection control coordinator. Surveillance data is collected and collated, infection rates are low. Covid-19 is well prepared for with adequate supplies of personal protective equipment sighted. 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)
Standards	0	36	0	7	2	0	0
Criteria	0	84	0	7	2	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	Policies and procedures are in place that meet with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and relevant legislation. An information pack is available to residents/families prior to admission and contains information of their rights. Discussions with one registered nurse (RN), three caregivers and one housekeeper confirmed their familiarity with the Code. Staff have not completed training on the Code in the past 2 years (link 1.2.7.5).
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	The service has policies and procedures relating to informed consent and advanced directives. Informed consent for release of medical information, photograph and outings were present in five resident files reviewed. Resuscitation forms are completed by the competent resident. The general practitioner (GP) makes a medically indicated not for resuscitation decision in consultation with the family for the incompetent resident. Residents and relatives interviewed confirmed that information was provided to enable informed choices and that they were able to decline or withdraw their consent. Resident admission agreements were 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	Client right to access advocacy and services is identified for residents. Advocacy leaflets are available at the entry to the facility. The information pack provided to residents prior to entry includes advocacy information. The information identifies who the resident can contact to access advocacy services. Staff were aware of the right for advocacy and how to access and provide advocate information to residents if needed. Residents and family members interviewed were aware of their access to advocacy services.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents and relatives confirmed that visiting could occur at any time. Key people involved in the resident's life have been documented in the resident files. Residents verified that they have been supported and encouraged to remain involved in the community, including being involved in regular community groups. Entertainers are regularly invited to perform at the facility.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The service has a complaints policy that describes the management of complaints process. There are complaint forms available in the service entrance. Information about complaints is provided on admission. Interviews with residents and relatives confirmed an understanding of the complaints process. There have been two complaints made since the last audit, both were received in 2019. Documentation including follow-up meetings, discussions and resolution demonstrates that complaints are being managed.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	The Code and advocacy pamphlets are located at the main entrance of the service. On admission, the manager or RN discusses the information pack with the resident and the family/whānau. This includes the Code, complaints, and advocacy information. The service provides an open-door policy for concerns/complaints. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Three residents and four relatives interviewed identified they have been informed about the Code.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a	FA	Staff interviewed were able to describe the procedures for maintaining confidentiality of resident records, resident's privacy, and dignity. Residents and relatives interviewed reported that residents are able to choose to engage in activities and access community resources. There is an abuse and neglect policy in place. Staff have not completed training on privacy/dignity, abuse, and neglect in the past 2 years (link 1.2.7.5).

manner that has regard for their dignity, privacy, and independence.		
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	The service has guidelines for the provision of culturally safe services for Māori residents. On the day of the audit there was one resident that identified as Māori. The file of resident that identified as Māori , however, a Māori health plan had not been documented (link 1.3.5.2). The service has established links with a local Māori community member, Te Whira Akuhata who provides advice and guidance on cultural matters. Staff interviewed confirmed they are aware of the need to respond appropriately to maintain cultural safety.
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	Care planning and activities' goal setting includes consideration of spiritual, psychological, and social needs. Residents and family members interviewed indicated that they are asked to identify any spiritual, religious and/or cultural beliefs. Family members reported that they feel they are consulted, and that family involvement is encouraged. Staff have not completed training on cultural awareness in the past 2 years (link 1.2.7.5).
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	The staff employment process includes the signing of house rules. Job descriptions include responsibilities of the position and ethics, advocacy, and legal issues. The orientation programme provided to staff on induction includes an emphasis on privacy and personal boundaries.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service meets the individualised needs of residents with needs relating to rest home level care. There are policies and procedures to guide the facility to implement the quality management programme. There are a range of policies, procedures, and forms in place. Staffing policies include pre-employment, the requirement to attend orientation and ongoing in-service training. The service has an annual business plan for 2021 in place, including service overview and objectives. The manager is responsible for coordinating the internal audit programme. Monthly staff/quality meetings and six-monthly resident meetings are scheduled to be completed (link 1.2.3.7). Residents and relatives interviewed spoke positively about the care and support provided. Staff interviewed stated that they feel supported by management.

Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	PA Moderate	The manager promotes an open-door policy. Residents and family are informed prior to entry of the scope of services and any items they have to pay for that is not covered by the agreement. Accident/incident forms have a section to indicate if next of kin have been informed (or not) of an accident/incident. There was no documented notification to the next of kin in 14 of 15 accident/incident forms reviewed. Residents and relatives interviewed confirmed that the staff and management are approachable and available. The information pack is available in large print and advised that this can be read to residents.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Summerville Rest Home provides rest home level care for up to 15 residents. On the day of the audit there were 12 residents, including one resident on a mental health contract and two on ACC contracts. All other residents were on the age-related residential care (ARRC) agreement. Summerville Rest Home is owned by a non-New Zealand registered medical practitioner. He assumes the role of managing director only. The managing director manages the business remotely and is supported by the manager. The service is overseen by the manager who has been at Summerville Rest Home for over 30 years and in the manager role for 20 years. She has a Certificate in Management. She is supported by a part time RN who has been in the role for nine months and works a minimum of 12 hours a week. She has a Bachelor of Nursing. The service has an annual business plan for 2021 in place, including service overview and objectives. The manager has maintained eight hours of professional development in the past 12 months, including education sessions at the local district health board (DHB).
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 manager reported that in the event of her temporary absence, the RN fills the role with support from the senior care staff.

Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Low	Summerville Rest Home has a documented quality and risk management programme. There are policies and procedures to guide the facility to implement the quality management programme. Policies are reviewed two-yearly (last reviewed in July 2021) to meet the requirements of the relevant Health and Disability Services Standards 2008. The service has an annual business plan for 2021 in place, including service overview and objectives. Quality data is collated for accident/incidents, infection control, internal audits, complaints, and surveys. Staff/quality meetings are scheduled monthly to ensure staff communication and discuss quality data. There have not been any staff/quality meetings completed for 2021 year to date. Resident meetings are scheduled six-monthly. There have been no resident meetings conducted over the past year. The 2021 annual resident and relative satisfaction survey has been conducted with respondents advising that they are overall satisfied with the care and service they receive. An improvement area was identified and actioned around the laundry service. The service reviews all internal audits six-monthly and action plans are followed up. Corrective actions are completed for any internal audits that are not fully compliant. There is a Health and Safety and risk management system in place including policies to guide practice. There is a current hazard register, which was last reviewed in July 2021. Hazards are documented on the register and have interventions documented to manage the risk. Falls prevention strategies are in place, which include 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 service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	There is an incident reporting policy that includes definitions and outlines responsibilities. Fourteen accident/incident forms for the month of June, July and August 2018 were reviewed. The majority document timely review and follow-up (link 1.3.3.3). Neurological observations (Glasgow coma scale report) were documented and completed for two unwitnessed falls with potential head injury. There was no documented evidence that family had been notified for 14 of 15 incidents reviewed (link 1.1.9.1). Discussions with the manager confirmed an awareness of the requirement to notify relevant authorities in relation to essential notifications including section 31 notifications. There have been no section 31 notifications or outbreaks lodged since the last audit.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet	PA Low	There are human resources policies to support recruitment practices. Five staff files (one manager, one RN and three caregivers) were reviewed. The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience, and suitability for the role. Performance appraisals were current. A current practising certificate was sighted for the RN. The service has an orientation programme in place to provide new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and stated that they

the requirements of legislation.		believed new staff are adequately orientated to the service. The RN and caregivers' complete competencies relevant to their role such as medications. There is an education planner in place that covers compulsory education requirements over a two-year period. Not all compulsory education has been completed within the required two-year period. Education not completed includes abuse and neglect, cultural awareness, the code, privacy/dignity, sexuality/intimacy, spirituality/counselling, chemical safety, challenging behaviour, dementia and falls prevention. The RN has completed interRAI training and has also attended education sessions at the local DHB. The RN has access to external education through the DHB. There were two caregivers, that had level 3 Careerforce certificates.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	There is a policy on staff numbers and skills required. Skill mix is reviewed on a regular basis and reviewed in-line with resident numbers. The manager is onsite from 8 am until 4 pm, Monday to Friday and is on-call 24/7 for any non-clinical issues. There is a part-time RN onsite for 12 hours per week or more if required and is also available on-call 24/7 for any clinical issues. The local general practitioner (GP) also provides afterhours care if required and caregivers have access to the local ambulance service. The caregivers, residents and family members interviewed reported that there is sufficient staff on duty. There are two caregivers on duty on the morning shift, one caregiver on duty on the afternoon shift and one caregiver on the night shift. There is an additional caregiver who covers the 'tea' shift from 5 pm to 8 pm. Roster shortages or sickness are covered by casual or off duty staff. There is also a senior caregiver who lives onsite and is available for any assistance if required. There is a cleaner seven days a week from 8.30 am to 11.30 pm and an activities coordinator (role currently vacant) who works Monday to Friday from 10.30 am to 12 pm. The caregivers, residents and family members interviewed reported that there is sufficient staff on duty.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The service retains relevant and appropriate information to identify residents and track records. his includes information gathered at admission with the involvement of the family. Staff could describe the procedures for maintaining confidentiality of resident records and sign confidentiality statements. Files and relevant care and support information for residents is able to be referenced and retrieved in a timely manner.

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	The service has admission policies and processes in place. Residents receive an information booklet around admission processes and entry to the service. The registered nurse screens all potential residents prior to entry to services to confirm they meet the level of care provided at the facility. All residents are assessed prior to entry by the needs assessment service coordination (NASC) team. Assessments are available to the service on admission to the service. There is an information pack provided to all residents and their families on services available. Residents and or family/whānau are provided with associated information (e.g., information on their rights, the Code, complaints management, advocacy, and the admission agreement). The relatives and residents interviewed stated that they had received the information pack and had received sufficient information prior to and on entry to the service. Residents and relatives interviewed confirmed they received information prior to admission and discussed the admission process and admission agreement with the manager.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	There are guidelines for death, discharge, transfer, and follow-up. When transferring, all relevant information is documented and transferred with the resident. Resident transfer information is communicated to the receiving health provider or service. There is documented evidence of family notification for resident transfers, as sighted in the resident's file who had been transferred to hospital. The 'yellow envelope' system is used when residents are transferring to the DHB.
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.	PA Low	The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management. All medicines are stored securely. The RN and caregiver's complete annual medication competencies and medication education. The RN has a current syringe driver competency. The facility utilises a blister pack system for all medications. The RN checks all medication on arrival from the pharmacy. There were no resident's self-medicating on the day of the audit. There were no expired drugs on site. All eye drops were dated on opening. Ten paper-based medication charts were reviewed. All medication charts were legible, and medications were appropriately prescribed. 'As required' medications were prescribed appropriately with indications for use documented. Effectiveness of 'as required' medications administered were recorded in the progress notes. Allergies were documented, and all charts included photo identification. All long-term medications charts had been reviewed by the GP three monthly. There were no drugs in the medication fridge, however, the temperature of the medication room has not been recorded.
Standard 1.3.13: Nutrition, Safe	FA	All food is prepared and cooked onsite by the caregivers who are assigned to cooking duties on the roster. Baking and some food preparation is done by the night staff. There is a four weekly,

Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.		summer/winter menu in use that had been reviewed by a dietitian in February 2020. A food control plan with an expiry date of February 2022 is in place. The kitchen is clean, tidy and is well equipped. All perishable goods are date labelled. Food is procured from local commercial suppliers and the supermarket. Since the last audit, the kitchen benches have been replaced with stainless steel benches. Fridge and freezer temperatures are recorded daily using food control plan templates. The temperature checks of food on arrival and end-cooked food is recorded. Cleaning schedules are maintained. The main meal is at midday, and residents have a light meal in the evenings. Meals are served directly from the kitchen to the residents in the dining rooms adjacent. A tray service is available for residents who prefer not to dine in the dining room. The resident likes, and dislikes are noted on admission and known to the caregivers. Alternatives are offered. Special diets are accommodated. Care staff have completed safe food handling training during orientation. High calorie diets and supplements are offered for residents with weight loss, if needed. Lip plates and smaller serving plates are available to promote independence at mealtimes. Residents and relatives spoke positively about the meals and home baking.
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 service records the reason for declining (no beds available) service entry to potential residents should this occur and communicates this to potential residents/family/whānau. Anyone declined entry is referred back to the needs assessors or referring agency for appropriate placement and advice.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	The facility has embedded the interRAI assessment protocols within its current documentation. InterRAI assessments were evident in printed format in all files. All resident files included a recent interRAI assessment, however not all initial assessments have been completed within timeframes (link 1.3.3.3). Risk assessments are used for falls, and pressure when indicated as sighted in the resident files reviewed. The registered nurse maintains a folder containing a suite of assessments to be used as required.
Standard 1.3.5: Planning Consumers' service delivery	PA Low	Each resident has a long-term care plan in place which is linked to the interRAI assessment triggers and outcomes, and risk assessments completed by the registered nurse. The registered nurse utilises an

plans are consumer focused, integrated, and promote continuity of service delivery.		electronic care plan template which is then printed and is available for caregivers to read in the residents' paper-based file. The GP, allied services, the RN, activity staff, physiotherapist and other visiting health providers write their care notes in the resident file. The care plans were documented for each resident, however, not all care plans reflected residents' current needs. Caregivers interviewed were knowledgeable regarding individual resident cares. Short term care plans were utilised for acute and short-term needs including infections, and wounds. Residents and relatives interviewed confirmed that resident/family were involved in the development/evaluation of care plans.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	All resident files reviewed had care plans in place. Residents interviewed reported their needs were being met. Family members interviewed stated the care and support met their expectations for their relative. There was documented evidence of relative contact for any changes to resident health status. Continence products are available. Specialist continence advice is available as needed and this could be described by the RN interviewed. Caregivers and the RN interviewed, stated there is adequate continence and wound care supplies. Documentation was reviewed for two wounds – one chronic ulcer and one lesion. Both wounds had fully completed assessments, and wound management plans in place. Evaluation of the wounds (including photographs) indicated progression towards healing. There were no pressure injuries. Monitoring charts were in use and examples sighted included (but not limited to), weight and vital signs, blood glucose, pain, food and fluid, and behaviour monitoring as required.
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.	PA Low	The caregivers reported they are currently providing activities for residents. There is no set planner in place, and residents choose what they would like to do on the day. During the audit, residents were observed watching quiz programmes on the TV, completing word puzzles, crosswords and reading newspapers. The staff reported the group of residents residing at the facility chose not to participate in group activities, instead prefer completing individual word games and puzzles of their choosing. A group of residents enjoy watching the birds at the bird feeder on the smoking deck at the back of the facility. One resident funded by ACC has a caregiver who assists with activities for this resident. Activities include spending time with the resident for a general chat, assisting with puzzles and whatever the resident chooses. Caregivers have been documenting any visitors and some activities residents have been involved with which was evident in the residents' files. Staff and residents interviewed reported there had been outings to the community and entertainers visited the facility regularly prior to Covid-19 restrictions.

		When the activities coordinator was available, each resident had an activity assessment completed shortly after admission, which was reviewed annually, and six-monthly evaluations were completed, however, these have not been evidenced of being reviewed since February 2021. Residents interviewed stated they were satisfied watching TV programmes of their choosing in their bedrooms or completing word puzzles.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Low	Long term care plans had at times been updated to reflect changes in resident condition. Long term care plans had been reviewed six monthly, relatives and residents interviewed confirmed they are included in care plan reviews. Relatives stated they receive a copy of the care plans, and are invited to provide feedback, however, evidence of resident and relatives input was not always documented, and care plan reviews did not always reflect resident progression towards meeting goals. The GP reviews residents three monthly or when requested if issues arise or their health status changes. The GP was interviewed and stated that the staff communicate appropriately. Short-term care plans were evident for the care and treatment of residents. Short-term care plans are typically used for residents with infections and those who have wounds.
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	The service facilitates access to other services (medical and non-medical) and where access occurred, referral documentation is maintained. Residents and/or their family/whānau are involved as appropriate when referral to another service occurs. The registered nurse described the process around interRAI assessments to be completed for significant change in health status requiring a re-assessment of level of care. Relatives interviewed confirmed they were kept fully aware of all referrals made.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during	FA	Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Safety data sheets were readily accessible for staff. Chemicals were stored safely. Chemical bottles sighted have correct manufacturer labels. Personal protective clothing is available for staff and seen to be worn by staff when carrying out their duties on the day of audit, however, staff have completed chemical safety training (link 1.2.7.5).

service delivery.		
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building holds a current warrant of fitness, which expires 17 January 2022. The manager coordinates and authorises the contractors to carryout maintenance requests. There is a communication book used for the daily maintenance requests. Corrective actions are documented in the communication book. Electrical equipment has been tested and tagged annually. Medical equipment is calibrated annually. Essential contractors are available 24 hours a day. Hot water temperature monitoring is completed monthly with readings within acceptable ranges. The building has internal and external ramps on the ground floor, which provides easy access to all areas for residents requiring mobility aids. There is an open plan combined dining area/lounge area and a second lounge area available. There is outdoor seating and shading in place. The grounds are well maintained. There is a safety gate across the driveway. Residents were observed to be moving freely around the facility and to the gardens with the use of mobility aids.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	There are four resident communal toilets and a separate toilet for staff and visitors. There are three showers for residents. There is appropriate signage, easy clean flooring and fixtures and handrails appropriately placed. There are privacy locks on the doors on the showers and toilets. Residents interviewed confirmed staff provide the resident with privacy when attending to personal hygiene cares.
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	The rooms are spacious enough to meet the assessed needs of residents. Residents are able to manoeuvre mobility aids around their bed and personal space areas. All beds are of an appropriate height for the residents. Bedrooms are personalised with the resident's personal adornments and furniture if the resident wishes. Caregivers interviewed reported that rooms have sufficient space to allow cares to take place.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with	FA	The dining area and main lounge area is open plan. There is a second large lounge at the front of the building where residents can have visitors or spend time with quiet activities (currently used for relatives visiting residents under currently level 2 Covid-19 guidelines). Communal areas are easily accessible. There is adequate space to allow for individual and group activities to occur within the lounge.

safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.		
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	Caregivers and the housekeeper incorporate laundry duties into their day. Laundry procedures and cleaning duties are documented. There is a commercial washer and a commercial drier and sink in the laundry. Linen is dried outside on the clothesline where possible. The laundry door is locked to prevent resident entry when staff are not in attendance. Chemicals are stored safely in the manufacturer's containers in the laundry and in other locked areas. Safety datasheets are readily accessible. Protective clothing (gloves, aprons, and visors) is available for staff. The housekeeper interviewed was knowledgeable around infection control practices and chemical use. The housekeeper uses colour coded disposable cloths for different duties. Effectiveness of the cleaning and laundry service is monitored by the manager through resident and relative feedback, and the internal audit programme. Residents interviewed were satisfied with the cleaning and laundry services.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	PA Moderate	A fire evacuation plan has been updated and approved by the New Zealand Fire Service; letter dated 13 September 2021. There is an emergency and business continuity plan in place to ensure health, civil defence and other emergencies are included. Six-monthly fire evacuation practice documentation was sighted, with the last fire evacuation drill occurring on 26 August 2021. Fire training and security situations are part of orientation of new staff and include competency assessments. There are adequate supplies in the event of a civil defence emergency including sufficient food, water (bottled water supply), blankets and alternate gas cooking (BBQ and gas hobs in the kitchen). There are civil defence and pandemic outbreak supplies available, checked six-monthly. There is a first aid kit kept in the kitchen and nurses' station. Emergency equipment is available at the facility. Short-term backup power for emergency lighting is in place. A first aid trained staff member is required to be on duty 24/7. Staff first aid certificates expired on 7 August 2021. The RN holds a current first aid certificate. There is a call bell system in place and there are call bells in the residents' rooms, and lounge/dining room areas. Residents were observed to have their call bells in close proximity.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe	FA	Bedrooms have an external window to allow natural lighting and ventilation. There are oil heaters in residents' rooms so they can control the temperatures of their rooms. There are panel heaters in the corridors and an air conditioner/heat pump in the main residents' lounge. All areas have external windows. The residents and relatives confirmed the temperature of the facility is maintained at a

ventilation, and an environment that is maintained at a safe and comfortable temperature.		comfortable level.
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 registered nurse is the infection control coordinator. A current job description is on file and has been signed. The infection prevention and control (IPC) programme is appropriate for the size and complexity of the service. The facility has a suite of infection prevention and control policies. The infection prevention and control practices are authorised and reviewed annually by the RN. Visitors are asked not to visit if they have been unwell. Influenza and Covid-19 vaccines are offered to residents and staff. There are hand sanitisers throughout the facility and adequate supplies of personal protective equipment. There have been no outbreaks since the previous audit. All visitors and contractors to the facility are required to complete a wellness declaration and sign the register for contact tracing purposes.
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 organisation.	FA	Infection control is managed by the infection control coordinator (RN) who has been in the role since March 2021. The infection control coordinator has undertaken online infection control training. The infection control coordinator has access to infection control personnel within the district health board, laboratory services and the GP. Covid-19 has been well prepared for with the implementation of policies to include Covid-19 precautions. A resource folder is in place and the pandemic plan has been updated in conjunction with the DHB, which includes an emergency information folder with relevant resident information. Adequate supplies of masks, gloves, gowns, hand sanitiser and visors were sighted during the audit. Education and information have been provided around the use of personal protective equipment and correct procedure for donning and doffing personal protective equipment. Staff interviewed were familiar with infection control procedures. Infection control is discussed at handover meetings.
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	FA	The infection control manual outlines a range of policies, standards and guidelines and includes the infection control programme, responsibilities and oversight, training, and education of staff. The policies have been reviewed annually. The Covid-19 policy has been obtained from the Health, Quality and Safety commission.

available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.		
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 describes education provided to staff around standard precautions and hand washing during the orientation process. Questionnaires are provided for staff to complete around handwashing, and standard precautions, then a practical session is held to supervise technique. Extra training, videos and posters were provided to staff around donning and doffing personal protective equipment. A record of attendance is maintained.
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	There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place appropriate to the complexity of service provided. The infection control coordinator collects the infection rates each month, identifies trends and uses the information to initiate quality activities within the facility including training needs. Caregivers interviewed were aware of infection rates. Systems are in place and are appropriate to the size and complexity of the facility. There have been no outbreaks since the last audit.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Summerville Rest Home has restraint minimisation and safe practice policies and procedures in place. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. There were no residents requiring restraint or enablers at the time of the audit. The service is committed to maintaining a restraint-free environment.

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 1.1.9.1 Consumers have a right to full and frank information and open disclosure from service providers.	PA Moderate	Accident/incident forms have a section to indicate if next of kin have been informed (or not) of an accident/incident. Only one of 15 incident forms reviewed identified that family had been informed.	Fifteen accident/incident forms were reviewed for June, July, and August 2021. There was no documented notification to the next of kin for 14 of 15 accident/incident forms reviewed.	Ensure that documentation reflects that next of kin are notified of any resident incidents/accidents or if not notified, the reason why should be documented. 60 days
Criterion 1.2.3.5 Key components of service delivery shall be explicitly	PA Low	Staff/quality meetings are scheduled monthly and resident meetings are scheduled six-monthly; however meetings have not	There have been no staff/quality meetings or resident meetings documented as held for 2021 year to	Ensure meetings are held as scheduled.

linked to the quality management system.		occurred as scheduled.	date.	90 days
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	There is an education planner in place that covers compulsory education requirements over a two-year period; however not all required training has been completed.	Not all compulsory training included in the two-yearly education planner has been completed. Compulsory training not completed includes abuse and neglect, cultural awareness, the code, privacy/dignity, sexuality/intimacy, spirituality/counselling, chemical safety, challenging behaviour, dementia and falls prevention.	Ensure that all compulsory staff training included in the two-yearly education planner is completed. 90 days
Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Low	Medication charts were legible, and medications were administered as prescribed in the medication charts. Signing sheets were fully completed and efficacy of 'as required' medications has been recorded. All medications no longer required are returned to the pharmacy. Medications are stored securely, however, the temperature of the medication room has not been recorded.	The temperature of the medication room has not been recorded to evidence the temperature is maintained at less than 25 degrees.	Ensure the medication room temperatures are recorded daily. 60 days
Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Low	Risk assessments and interRAI assessments are completed for all residents, however not all interRAI assessments were completed within expected timeframes. The caregivers document progress notes at the end of each shift, however, the registered nurse documentation does not always reflect follow-up of incidents.	(i) Four of six resident files reviewed did not have interRAI assessments completed or reviewed within expected timeframes. (ii) Progress notes for two residents who have had an incident report completed did not evidence follow-up by the registered nurse.	(i) Ensure interRAI assessments are completed in a timely manner. (ii) Ensure progress notes document RN follow-up of incidents.

				90 days
Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	PA Low	All residents had a long-term care plan in place, which is electronic and templated. The registered nurse adapts the care plans around residents' needs, and then prints a copy for the paper-based resident's file. Short term care plans were sighted for short term/acute needs such as infections and wounds, however, not all care plan interventions were reflective of current residents' needs.	i) One resident has had a decline in condition which was well documented in the progress notes, however, the extra support and assistance the resident required was not documented in the long-term care plan. ii) One resident identified as Māori and is Catholic. There were no interventions included in the cultural/spiritual section of the care plan around resident preferences or affiliations, or spiritual practices including whether the priest visited for communion. iii) One resident has a diagnosis of dementia and is obese. There were no individualised strategies documented around the management of behaviours, and no interventions around the management of obesity.	(i)-(iii) Ensure there are individualised interventions documented to meet all resident needs. 90 days
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.	PA Low	There is currently no employed activities coordinator and the manager reported they are currently recruiting; however, responses have been low. Three of five resident files reviewed had an activities assessment and plan completed, however reviews had not been documented six-monthly. Two residents admitted to the service in 2021 have no activity assessment or plan documented.	i) There was no documentation of daily activities that have taken place. ii) There was no activities assessment or plan documented for two of five residents. iii) Three of five residents did not have a six-monthly review of their activities plan.	i) Ensure there is a record of all resident activities maintained. ii-iii) Ensure all residents have a current activity assessment, and plan documented

				tailored to residents' preferences, which is reviewed at least six-monthly. 90 days
Criterion 1.3.8.2 Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.	PA Low	The resident care plan reviews have occurred six-monthly; however documentation does not reflect resident and/or relatives input or resident progression towards meeting goals.	i) Care plan reviews in all five files reviewed did not reflect resident and/or relative input. ii) Documentation does not reflect resident progression towards meeting goals in all five files .	Ensure the care plan review documents resident, relative input and evidences residents' progression towards meeting care plan goals. 90 days
Criterion 1.4.7.1 Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.	PA Moderate	There is an emergency and business continuity plan in place to ensure health, civil defence and other emergencies are included. A first aid trained staff member is required to be on duty 24/7.	There is not always a first aid trained staff member on duty 24/7 as staff first aid certificates expired on 7 August 2021.	Ensure that there is a first aid trained staff member on duty 24/7 and that staff have current first aid certificates. 60 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.

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End of the report.