# Selwyn Care Limited - Sarah Selwyn

## Current Status: 8 October 2014

**The following summary has been accepted by the Ministry of Health as being an accurate reflection of the** **Surveillance Audit conducted against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) on the audit date(s) specified.**

## General overview

Sarah Selwyn is a purpose built facility that is part of a larger complex and village. The facility provides residential care for up to 81 residents at rest home and hospital level care. Occupancy on the day of the audit was 76 residents, two residents at rest home level care and 74 residents at hospital level care.

The facility manager (care lead) is a registered nurse and has been in the role for four months. She is supported by an experienced registered nurse who has been in the role for over five years. The assistant care lead role is currently being recruited. There is a stable workforce. All residents and relatives interviewed were happy with the care and support provided by staff and management.

Five of seven shortfalls identified at the previous audit have been addressed. These are around clinical follow up following incidents, staff orientation, care plans, evaluations and medication administration documentation. There has been some improvement around meeting minutes but further improvement continues to be required. Improvement continues to be required around performance appraisals.

This audit has identified further improvements required around wound dressing timeframes.

## Audit Summary as at 8 October 2014

Standards have been assessed and summarised below:

### Key

| **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 |
|  | 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 |

### Consumer Rights as at 8 October 2014

|  |  |  |
| --- | --- | --- |
| 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. |

### Organisational Management as at 8 October 2014

|  |  |  |
| --- | --- | --- |
| 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. |

### Continuum of Service Delivery as at 8 October 2014

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

### Safe and Appropriate Environment as at 8 October 2014

|  |  |  |
| --- | --- | --- |
| 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. |

### Restraint Minimisation and Safe Practice as at 8 October 2014

|  |  |  |
| --- | --- | --- |
| 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. |

### Infection Prevention and Control as at 8 October 2014

|  |  |  |
| --- | --- | --- |
| 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. |

# HealthCERT Aged Residential Care Audit Report (version 4.2)

## **Introduction**

This report records the results of an audit against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) of an aged residential care service provider. The audit has been conducted by an auditing agency designated under 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).

It is important that auditors restrict their editing to the content controls in the document and do not delete any content controls or any text outside the content controls.

## **Audit Report**

|  |  |
| --- | --- |
| **Legal entity name:** | Selwyn Care Limited |
| **Certificate name:** | Selwyn Care Limited - Sarah Selwyn |

|  |  |
| --- | --- |
| **Designated Auditing Agency:** | Health and Disability Auditing New Zealand Limited |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Types of audit:** | Surveillance Audit | | | |
| **Premises audited:** | Sarah Selwyn | | | |
| **Services audited:** | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) | | | |
| **Dates of audit:** | **Start date:** | 8 October 2014 | **End date:** | 9 October 2014 |

**Proposed changes to current services (if any):**

|  |  |
| --- | --- |
| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 76 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXXXXX | **Hours on site** | 12 | **Hours off site** | 5 |
| **Other Auditors** | XXXXXXX | **Total hours on site** | 24 | **Total hours off site** | 10 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXXX |  |  | **Hours** | 2 |

## **Sample Totals**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 36 | Total audit hours off site | 17 | Total audit hours | 53 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 8 | Number of staff interviewed | 20 | Number of managers interviewed | 3 |
| Number of residents’ records reviewed | 7 | Number of staff records reviewed | 5 | Total number of managers (headcount) | 3 |
| Number of medication records reviewed | 14 | Total number of staff (headcount) | 61 | Number of relatives interviewed | 2 |
| Number of residents’ records reviewed using tracer methodology | 2 |  |  | Number of GPs interviewed | 1 |

## **Declaration**

I, XXXXXXX, Director of Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Act.

I confirm that:

|  |  |  |
| --- | --- | --- |
| a) | I am a delegated authority of Health and Disability Auditing New Zealand Limited | Yes |
| b) | Health and Disability Auditing New Zealand Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise | Yes |
| c) | Health and Disability Auditing New Zealand Limited has developed the audit summary in this audit report in consultation with the provider | Yes |
| d) | this audit report has been approved by the lead auditor named above | Yes |
| e) | the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook | Yes |
| f) | if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider | Yes |
| g) | Health and Disability Auditing New Zealand Limited has provided all the information that is relevant to the audit | Yes |
| h) | Health and Disability Auditing New Zealand Limited has finished editing the document. | Yes |

Dated Tuesday, 4 November 2014

## **Executive Summary of Audit**

**General Overview**

Sarah Selwyn is a purpose built facility that is part of a larger complex and village. The facility provides residential care for up to 81 residents at rest home and hospital level care. Occupancy on the day of the audit was 76 residents, two at rest home level care and 74 residents at hospital level care.

The facility manager (care lead) is a registered nurse and has been in the role for four months. She is supported by an experienced registered nurse and has been in the role for over five years. The assistant care lead role is currently being recruited. There is a stable workforce. All residents and relatives interviewed were happy with the care and support provided by staff and management.

Five of seven shortfalls identified at the previous audit have been addressed. These are around clinical follow up following incdients, staff orientation, care plans, evaluations and medication administration documentation. There has been some improvement around meeting minutes but further improvement continues to be required. Improvement continues to be required around performance appraisals.

This audit has identified further improvements required around wound dressing timeframes.

**Outcome 1.1: Consumer Rights**

There is an open disclosure and interpreters policy that staff understand. Family/friends are able to visit at any time and interviews verified on-going involvement with community activity is supported. There is a complaints policy supporting practice and an up to date register. Staff interviews confirmed an understanding of the complaints process.

**Outcome 1.2: Organisational Management**

Sarah Selwyn has an established quality and risk management system that supports the provision of clinical care and support. An annual resident/relative satisfaction survey is completed and there are regular resident/relative meetings. Quality and risk performance is reported across the facility meetings and also to the organisation's management team. Benchmarking and analysis of quality data occurs on a monthly basis. Benchmarking reports demonstrate that the data collected has reflected care and service. There are improvements required around discussion of incident and infection trends in meetings. There are human resources standard operation procedures including recruitment, selection, orientation and staff training and development. There is an improvement required around staff annual appraisals. There is a in-service training programme covering relevant aspects of care and support and mandatory study days for staff on core topics. The organisational staffing policy aligns with contractual requirements and includes skill mixes. Staffing levels are monitored.

**Outcome 1.3: Continuum of Service Delivery**

Registered nurses and the clinical nurse manager are responsible for each stage of service provision. Resident assessments, care plans, progress notes, and medical/allied health notes are kept electronically to guide staff in the safe delivery of care. Care plan interventions are comprehensively completed. Care plans are reviewed at least six monthly and demonstrate an integrated care process. There is an improvement required around wound reviews.

The service provides a comprehensive activity programme that involves residents in the community. The activity programme is focused on creating a regenerative community which is as home-like as possible, offering residents relationships and companionship, the opportunity to maximize their independence, pursue their individual interests and maintain their strengths, both physical and mental.

Medications management was reviewed. Competencies are completed, medication profiles are legible, up to date and reviewed by the general practitioner three monthly or earlier if necessary. The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. There are food service policies and procedures and a link to a dietitian. Changes to residents’ dietary needs are communicated to the kitchen and special diets are noted.

**Outcome 1.4: Safe and Appropriate Environment**

Documentation provides evidence there are appropriate systems in place to ensure the residents’ physical environment and facilities are fit for their purpose. There is a current building warrant of fitness.

**Outcome 2: Restraint Minimisation and Safe Practice**

The restraint minimisation procedure states the purpose of restraint is 'To minimise the use of restraint while providing a safe environment for residents, staff and visitors. To ensure that when restraint is practised, it occurs in a safe and respectful manner for the minimum length of time'. The service currently has 11 residents requiring restraint and none using enablers.

**Outcome 3: Infection Prevention and Control**

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 uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking infection control data.

## **Summary of Attainment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 15 | 0 | 2 | 1 | 0 | 0 |
| **Criteria** | 0 | 42 | 0 | 2 | 1 | 0 | 0 |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 32 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 56 |

## **Corrective Action Requests (CAR) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | 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 |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.3.6 | Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | Incident and infection trend analysis and discussions of outcomes are not well documented in meeting minutes. | Ensure incident and infection trend analysis and discussions of outcomes are documented in meeting minutes. | 90 |
| HDS(C)S.2008 | Standard 1.2.7: Human Resource Management | Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.7.3 | The appointment of appropriate service providers to safely meet the needs of consumers. | PA Low | Two of five staff files sampled do not have current performance appraisals. | Ensure that all staff have current performance appraisals. | 180 |
| HDS(C)S.2008 | Standard 1.3.6: Service Delivery/Interventions | Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.6.1 | The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Moderate | Five of the 34 wounds did not have dressings replaced within the stated time frame. | Ensure wounds are reviewed within stated timeframes. | 90 |

## **Continuous Improvement (CI) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |

# NZS 8134.1:2008: Health and Disability Services (Core) Standards

## **Outcome 1.1: Consumer Rights**

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, facilitates informed choice, minimises harm, and acknowledges cultural and individual values and beliefs.

#### Standard 1.1.9: Communication **(**HDS(C)S.2008:1.1.9)

Service providers communicate effectively with consumers and provide an environment conducive to effective communication.

ARC A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1b.ii; D16.4b; D16.5e.iii; D20.3 ARHSS A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1bii; D16.4b; D16.53i.i.3.iii; D20.3

**Attainment and Risk:** FA

**Evidence:**

Accident/incidents, complaints and incident/injury management procedures alert staff around frank open disclosure and their responsibility to notify family/next of kin of any accident/incident that occurs.

The five registered nurses (RN), interviewed stated that they record contact with family/whanau in the progress notes. Family communication was documented in all files reviewed. Accident/incident forms have a section to indicate if family/whanau have been informed (or not) of an accident/incident. Fourteen incident forms for September 2014 reviewed identified that family were notified. Families often give instructions to staff regarding what they would like to be contacted about and when, should an accident/incident of a certain type occur. This is documented in the resident files. Incidents/accidents are benchmarked against other Selwyn facilities and externally with another aged care provider.

A residents/relatives meeting occurs six monthly. There is an annual satisfaction survey. Feedback from the survey indicated residents and family are satisfied with the service.

There is a communication and interpreters services standard operations procedures (SOP). Access to DHB interpreter services is available.

D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry

D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.

D16.4b Two of two family members (both hospital) stated that they are always informed when their family members health status changes.

D11.3 The information pack is available in large print and advised that this can be read to residents if required.

##### **Criterion 1.1.9.1 (HDS(C)S.2008:1.1.9.1)**

Consumers have a right to full and frank information and open disclosure from service providers.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.1.9.4 (HDS(C)S.2008:1.1.9.4)**

Wherever necessary and reasonably practicable, interpreter services are provided.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.1.13: Complaints Management **(**HDS(C)S.2008:1.1.13)

The right of the consumer to make a complaint is understood, respected, and upheld.

ARC D6.2; D13.3h; E4.1biii.3 ARHSS D6.2; D13.3g

**Attainment and Risk:** FA

**Evidence:**

The complaints SOP documents the responsibility of the facility manager to ensure all complaints (verbal or written), are fully documented and thoroughly investigated. There is a complaints process flowchart. A record of all complaints per month are entered into the Selwyn database. The number of complaints received each month is reported monthly to care services via the facility benchmarking report. Complaints forms are prominent around the facility. Complaints are documented including resolution. Verbal complaints are also included. Discussion with eight residents (two rest home and six hospital) and two of two family members (both hospital) confirmed they were provided with information on complaints and complaints forms and all described having a concern addressed immediately. Eight complaints were reviewed for 2014 (all complaints for 2014). All were documented with resolution.

D13.3h: A complaints procedure is provided to residents and family members within the information pack at entry.

##### **Criterion 1.1.13.1 (HDS(C)S.2008:1.1.13.1)**

The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.1.13.3 (HDS(C)S.2008:1.1.13.3)**

An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

## **Outcome 1.2: Organisational Management**

Consumers receive services that comply with legislation and are managed in a safe, efficient, and effective manner.

#### Standard 1.2.1: Governance **(**HDS(C)S.2008:1.2.1)

The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.

ARC A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.3d; D17.4b; D17.5; E1.1; E2.1 ARHSS A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.5

**Attainment and Risk:** FA

**Evidence:**

Sarah Selwyn is a purpose built facility that is part of a larger complex and village. The facility provides residential care for up to 81 residents at rest home and hospital level care. Occupancy on the day of the audit was 76 residents, two at rest home level care and 74 residents at hospital level care. There are currently no residents under the medical component of the contract.

Selwyn has an overall mission statement "to deliver quality services that are responsive to the ageing person and their family.” The organisational model of care is called "The Selwyn Way.” The four key values within the model are: faith, care, independence, and wellness. A copy of the model is given to residents and family members in the information pack There is a 2013 - 2017 strategic plan that contains the organisations seven goals a) charitable mission, b) continuum of care, c) centre of excellence, d) partnership (with key organisations including DHB's and Ministry of Health),e) brand, f) environmental sustainability and g) financial strength.

There is a Selwyn's 2014 annual business plan and risk management plan. The goals of the business plan and risk management plan align with the organisations strategic plan. The business plan goals are strategic, objective, tactical and measurable. Additionally, each Selwyn facility develops an annual quality plan as sighted at Sarah Selwyn.

Selwyn has robust quality and risk management systems implemented across its facilities. Across all Selwyn facilities collated data including incidents/accidents, infection control, complaints and restraint is analysed and benchmarked internally. Selwyn also benchmarks with another external provider. These systems were evidenced at Sarah Selwyn.

The care lead (facility manager) is a registered nurse and has been in the role for four months with significant experience in aged care management roles. She is supported by an experienced registered nurse and has been in the role for over four years while the assistant care lead position is recruited, and a stable workforce.

There are job descriptions for both positions that include responsibilities and accountabilities.

Selwyn provides a comprehensive orientation and training/support programme for their managers. Managers and clinical managers attend meetings and training at head office. The organisation is a member of the NZACA and supports managers to attend the conference each year. Sessions from the conference are then presented to other managers who have been unable to attend, and summarised for other members of the senior leadership team.

ARC, D17.3di (rest home), D17.4b (hospital): The manager has maintained at least eight hours annually of professional development activities related to managing a rest home and hospital.

##### **Criterion 1.2.1.1 (HDS(C)S.2008:1.2.1.1)**

The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.1.3 (HDS(C)S.2008:1.2.1.3)**

The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.2.3: Quality And Risk Management Systems **(**HDS(C)S.2008:1.2.3)

The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.

ARC A4.1; D1.1; D1.2; D5.4; D10.1; D17.7a; D17.7b; D17.7e; D19.1b; D19.2; D19.3a.i-v; D19.4; D19.5 ARHSS A4.1; D1.1; D1.2; D5.4; D10.1; D16.6; D17.10a; D17.10b; D17.10e; D19.1b; D19.2; D19.3a-iv; D19.4; D19.5

**Attainment and Risk:** PA Low

**Evidence:**

Sarah Selwyn has a quality and risk system that is being implemented. The facility manager is directly involved in operations at the facility. Interviews with 14 caregivers and five RN’s stated that there was a culture of quality improvements. The previous audit identified that meeting minutes were not detailed enough to demonstrate quality and risk performance. Meeting minutes now contain information regarding, corrective actions, outcomes or timelines around incidents, accidents, complaints and internal audits. RN monthly meeting minutes contain information on timelines, responsibilities and outcomes of actions taken or planned. Issues raised in resident meeting minutes (six monthly), are reflected in staff meeting minutes. However incident and infection trend analysis and discussions of outcomes are not well documented. Further improvement is required. The service has standard operations procedures (SOP's) and associated systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. All Selwyn facilities have access to all organisational standard operation procedures. These procedures have been developed in line with current accepted best and/or evidenced based practice and are reviewed regularly. The content of SOP's are detailed to allow effective implementation by staff. A number of core clinical components including infection control and restraint have education packages for staff which are based on their SOP's and were developed by the director of nursing. SOP's are reviewed at head office level and feedback is gained at facility level.

The service has a health and safety management SOP and this includes the identification of a health and safety rep. Security and safety procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency.

Key components of the quality management system link to the monthly health and safety/quality meetings. Each department provides quality reports on a monthly basis. Monthly accident/incident data is entered into the Selwyn data base and the quality and education manager develops a monthly quality improvement report for each facility. Benchmarking graphs are generated from the data. The service has linked the complaints process with its quality management system and complaints are benchmarked. The service also communicates this information to staff and at other relevant meetings so that improvements are facilitated. There is an infection control register which is held electronically in which all infections are documented each month. A range of infection control internal audits are planned and undertaken three monthly throughout the year. Results are forwarded to the staff meetings.

Health and safety and a hazard register is completed. Health and safety internal audits are completed. Analysis of results is completed and provided across the organisation.

All facilities restraint coordinators meets six monthly at head office. These meetings include a comprehensive review of restraint/enabler use. Restraint and enabler internal audits are completed three monthly.

There is a quality and risk management process being implemented at Sarah Selwyn. Monitoring programme includes (but not limited to); cleaning, hot water, laundry, medication, call bells and infection control. Frequency of monitoring is determined by the internal audit schedule. Audit summaries and action plans are completed where a noncompliance is identified. Issues and scores are entered into the database. Any audit that scores less than 100% has a quality improvement plan (QIP) generated by the manager. Selwyn is active in analysing data collected. Benchmarking reports are generated throughout the year to review performance over a 12 month period. The service continues to collect data to support the implementation of QIP's. Feedback is provided to all facilities via graphs

There is a comprehensive health and safety/risk management programme in place. Hazard management SOP guides practice. There is a Selwyn health & safety plan.

D19.3 There are implemented risk management and health and safety SOP's in place including accident and hazard management.

D19.2g Falls prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls.

##### **Criterion 1.2.3.1 (HDS(C)S.2008:1.2.3.1)**

The organisation has a quality and risk management system which is understood and implemented by service providers.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.3.3 (HDS(C)S.2008:1.2.3.3)**

The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.3.4 (HDS(C)S.2008:1.2.3.4)**

There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.3.5 (HDS(C)S.2008:1.2.3.5)**

Key components of service delivery shall be explicitly linked to the quality management system.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.3.6 (HDS(C)S.2008:1.2.3.6)**

Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.

**Attainment and Risk:** PA Low

**Evidence:**

Sarah Selwyn has a quality and risk system that is being implemented. The facility manager is directly involved in operations at the facility. Interviews with 14 caregivers and five RN’s stated that there was a culture of quality improvements. The previous audit identified that meeting minutes were not detailed enough to demonstrate quality and risk performance. Meeting minutes now contain information regarding, corrective actions, outcomes or timelines around incidents, accidents, complaints and internal audits. RN monthly meeting minutes contain information on timelines, responsibilities and outcomes of actions taken or planned. Issues raised in resident meeting minutes (six monthly), are reflected in staff meeting minutes.

**Finding:**

Incident and infection trend analysis and discussions of outcomes are not well documented in meeting minutes.

**Corrective Action:**

Ensure incident and infection trend analysis and discussions of outcomes are documented in meeting minutes.

**Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.3.7 (HDS(C)S.2008:1.2.3.7)**

A process to measure achievement against the quality and risk management plan is implemented.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.3.8 (HDS(C)S.2008:1.2.3.8)**

A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.3.9 (HDS(C)S.2008:1.2.3.9)**

Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:  
(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;  
(b) A process that addresses/treats the risks associated with service provision is developed and implemented.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.2.4: Adverse Event Reporting **(**HDS(C)S.2008:1.2.4)

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.

ARC D19.3a.vi.; D19.3b; D19.3c ARHSS D19.3a.vi.; D19.3b; D19.3c

**Attainment and Risk:** FA

**Evidence:**

D19.3b; The service collects incident and accident data. There is an incident reporting standard operations procedure and an incident/injury management process that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise or prevent further incidents. The service documents and analyses incidents/accidents, unplanned or unwanted events and provides feedback to the service and staff so that improvements are made. Individual incident reports are completed for each incident/accident. The data is linked to the organisation's benchmarking programme and this is used for comparative purposes.

Fourteen incident forms were reviewed across the service for September 2014 and all incidents demonstrated full clinical follow up by a registered nurse/clinical coordinator including neuro observations for three forms where these were required. The previous shortfall has now been addressed.

D19.3c Selwyn has a standard operations procedure that describes responsibilities around reporting of a serious harm event. Discussions with service management, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications.

##### **Criterion 1.2.4.2 (HDS(C)S.2008:1.2.4.2)**

The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.4.3 (HDS(C)S.2008:1.2.4.3)**

The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.2.7: Human Resource Management **(**HDS(C)S.2008:1.2.7)

Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.

ARC D17.6; D17.7; D17.8; E4.5d; E4.5e; E4.5f; E4.5g; E4.5h ARHSS D17.7, D17.9, D17.10, D17.11

**Attainment and Risk:** PA Low

**Evidence:**

A register of qualified nurses practising certificates is maintained (viewed). There are comprehensive human resources SOP's including recruitment, selection, orientation, staff training and development. Three of five staff files reviewed (two registered nurses, two caregivers and one activities coordinator), had up to date performance appraisals. The previously identified shortfall around performance appraisals continues to require improvement. Appointment documentation is seen on file including signed contracts, job descriptions, training and reference checking. The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme includes documented competencies. New staff are buddied during orientation and during this period they do not carry a clinical load. Five of five staff files sampled have completed orientation documentation in the file. This is an improvement since the previous audit. . Staff interviewed (14 caregivers, five RN's and one activities coordinator), were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. The Selwyn education standard operation procedure identifies the mandatory training for core topics and refresher training required for each role and the frequency that this is required to be completed. An education database is under development to facilitate the monitoring of this requirement. The annual education schedule is being implemented. External education is available via the DHB. There is evidence on RN staff files of external training. Discussion with staff and management confirmed that a comprehensive in-service training programme in relevant aspects of care and support is in place. Education is an agenda item of the monthly staff meetings. A competency programme is in place. Core competencies are completed annually and a record of completion is maintained - signed competency questionnaires sighted in reviewed files. Staff interviewed were aware of the requirement to complete competency training.

D17.7d: There are implemented competencies for registered nurses related to specialised procedure or treatment including (but not limited to); medication, restraint and wound care.

##### **Criterion 1.2.7.2 (HDS(C)S.2008:1.2.7.2)**

Professional qualifications are validated, including evidence of registration and scope of practice for service providers.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.7.3 (HDS(C)S.2008:1.2.7.3)**

The appointment of appropriate service providers to safely meet the needs of consumers.

**Attainment and Risk:** PA Low

**Evidence:**

There are comprehensive human resources SOP's including recruitment, selection, orientation, staff training and development. Three of five staff files reviewed (two registered nurses, two caregivers and one activities coordinator), had up to date performance appraisals. Appointment documentation is seen on file including signed contracts, job descriptions, training and reference checking.

**Finding:**

Two of five staff files sampled do not have current performance appraisals.

**Corrective Action:**

Ensure that all staff have current performance appraisals.

**Timeframe (days):** 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.7.4 (HDS(C)S.2008:1.2.7.4)**

New service providers receive an orientation/induction programme that covers the essential components of the service provided.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.7.5 (HDS(C)S.2008:1.2.7.5)**

A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.2.8: Service Provider Availability **(**HDS(C)S.2008:1.2.8)

Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.

ARC D17.1; D17.3a; D17.3 b; D17.3c; D17.3e; D17.3f; D17.3g; D17.4a; D17.4c; D17.4d; E4.5 a; E4.5 b; E4.5c ARHSS D17.1; D17.3; D17.4; D17.6; D17.8

**Attainment and Risk:** FA

**Evidence:**

The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. Care staff reported that staffing levels and the skill mix was appropriate and safe. All residents and family members interviewed stated that they felt there was sufficient staffing. The service has a staffing levels SOP implemented, which determines that the care lead or the care lead assistant (both registered nurses), will be on-call at all times, that at least one staff member on duty will hold a current first aid qualification and that new staff must be rostered on duty with an experienced staff member during the orientation phase of their employment. These standards are evident on review of the weekly rosters and discussions with staff. The senior registered nurse covers the facility manager during absences and holidays. A regional Selwyn physiotherapist provides physiotherapy services for the facility at least once a week. There is daily input from a physiotherapy aid.

##### **Criterion 1.2.8.1 (HDS(C)S.2008:1.2.8.1)**

There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

## **Outcome 1.3: Continuum of Service Delivery**

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.

#### Standard 1.3.3: Service Provision Requirements **(**HDS(C)S.2008:1.3.3)

Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.

ARC D3.1c; D9.1; D9.2; D16.3a; D16.3e; D16.3l; D16.5b; D16.5ci; D16.5c.ii; D16.5e ARHSS D3.1c; D9.1; D9.2; D16.3a; D16.3d; D16.5b; D16.5d; D16.5e; D16.5i

**Attainment and Risk:** FA

**Evidence:**

Sarah Selwyn uses a computer system. All parts of the integrated care including (but not limited to) assessments/care plans, progress notes, observations and evaluations are computerised. The registered nurses (R/N’s) undertake the assessments on admission. The initial assessment and support plan is completed within 24 hours and the key areas of the assessment a care summary (care plan). There is documented evidence that the care plans were reviewed by registered nurses and amended when current health changes. Electronic records identify dates that amendments were made and by whom.

Of the seven care plans sampled (one rest home and six hospital), six have a documented care plan evaluation completed. The seventh resident is a recent admission so evaluation not due. Changes to health status are identified in the electronic evaluation transfer into the care plan in all seven files sampled. Activity assessments and activities care plans were completed by the activities coordinator and integrated into the overall electronic care plan in all seven files sampled.

Seven of the seven resident files reviewed identified that the general practitioner (GP) had seen the resident within two working days. Residents are seen by the general practitioner one to three monthly. Medtech computer programme includes all doctor/physio/allied health records. These are able to be cut and pasted into the computer system. GP’s visit at least two days a week or more frequently as required.

A range of assessment tools were completed in resident files on admission and evaluated three monthly or as required. These include (but not limited to): pain, skin, nutrition, continence, behaviour and falls risk. A comprehensive initial nursing assessment, care plan and goals of care are individually developed on admission. There is documented evidence of resident/family involvement in care planning and evaluation.

Progress notes are written daily by R/N’s. Caregivers write in daily forms such as daily walks and bowel movements. All seven resident files identify integration of allied health personnel (physiotherapist, GP, dietician, podiatrist) and a team approach is evident.

Tracer methodology rest home:

*XXXXXX This information has been deleted as it is specific to the health care of a resident*.

Tracer methodology hospital:

*XXXXXX This information has been deleted as it is specific to the health care of a resident*

##### **Criterion 1.3.3.1 (HDS(C)S.2008:1.3.3.1)**

Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.3.3.3 (HDS(C)S.2008:1.3.3.3)**

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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.3.3.4 (HDS(C)S.2008:1.3.3.4)**

The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.3.5: Planning **(**HDS(C)S.2008:1.3.5)

Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.

ARC D16.3b; D16.3f; D16.3g; D16.3h; D16.3i; D16.3j; D16.3k; E4.3 ARHSS D16.3b; D16.3d; D16.3e; D16.3f; D16.3g

**Attainment and Risk:** FA

**Evidence:**

The previous audit identified that resident files sampled do not have interventions in the care plan relating to all areas of need. The seven files sampled for this audit (one rest home and six hospital) show that all files have interventions for all identified areas of need including falls management, challenging behaviours, weight management, diabetes, restraint and pressure risk management. The previous shortfall has now been addressed.

##### **Criterion 1.3.5.2 (HDS(C)S.2008:1.3.5.2)**

Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.3.6: Service Delivery/Interventions **(**HDS(C)S.2008:1.3.6)

Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.

ARC D16.1a; D16.1b.i; D16.5a; D18.3; D18.4; E4.4 ARHSS D16.1a; D16.1b.i; D16.5a; D16.5c; D16.5f; D16.5g.i; D16.6; D18.3; D18.4

**Attainment and Risk:** PA Moderate

**Evidence:**

Sarah Selwyn provides services for residents requiring rest home and hospital level of care. The care being provided is consistent with the needs of residents. Overall the lifestyle care plans are completed comprehensively. There is a short-term care plan that is used for acute or short-term changes in health status. Seven residents files were sampled (one rest home and six hospital),

Continence products are available. Continence assessments including bowel management and continence products identified for day use, night use, and other management are completed on admission and reviewed six monthly if applicable. Specialist continence advice is available as needed and this could be described. Continence management in-services and wound management in-service have been provided through the mandatory study days.

D18.3 and 4: Dressing supplies are available and a treatment room is stocked for use. There is a wound assessment and on -going assessment and treatment plan in place. The wound folders were reviewed. There are 34 wounds. One wound plan had photos and input from a nurse practitioner (NP) who is a wound specialist. The NP is available on request. Dressing interventions are clear. Dressing evaluations are done each time and the time frame for the next dressing is specified. Five of the 34 wounds did not have dressings replaced within the stated time frame. This is an area requiring improvement. There are eight pressure areas. Pressure area risk assessments are reviewed and interventions such as air alternating mattresses, roho cushions and two hourly turns identified, documented and implemented.

##### **Criterion 1.3.6.1 (HDS(C)S.2008:1.3.6.1)**

The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.

**Attainment and Risk:** PA Moderate

**Evidence:**

Sarah Selwyn provides services for residents requiring rest home and hospital level of care. The care being provided is consistent with the needs of residents. Overall the lifestyle care plans are completed comprehensively. There is a short-term care plan that is used for acute or short-term changes in health status. Seven residents files were sampled (one rest home and six hospital),

Continence products are available. Continence assessments including bowel management and continence products identified for day use, night use, and other management are completed on admission and reviewed six monthly if applicable. Specialist continence advice is available as needed and this could be described. Continence management in-services and wound management in-service have been provided through the mandatory study days.

D18.3 and 4: Dressing supplies are available and a treatment room is stocked for use. There is a wound assessment and on -going assessment and treatment plan in place. The wound folders were reviewed. There are 34 wounds. One wound plan had photos and input from a nurse practitioner (NP) who is a wound specialist. The NP is available on request. Dressing interventions are clear. Dressing evaluations are done each time and the time frame for the next dressing is specified.

**Finding:**

Five of the 34 wounds did not have dressings replaced within the stated time frame.

**Corrective Action:**

Ensure wounds are reviewed within stated timeframes.

**Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.3.7: Planned Activities **(**HDS(C)S.2008:1.3.7)

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.

ARC D16.5c.iii; D16.5d ARHSS D16.5g.iii; D16.5g.iv; D16.5h

**Attainment and Risk:** FA

**Evidence:**

The activities co-ordinator works 0800-1600, Monday to Friday. She has the National Certificate in care of the Elderly and the Eden Certificate and has been in the role for six years. The Activities assistant works Tuesday to Saturday 0900-1700, has the Eden certificate and is working on her ACE advanced. Both have considerable experience in the care of the elderly. They both provide a full, varied and interesting programme six days a week excluding public holidays, on Sundays there is a service at the onsite chapel and Caregivers assist any residents that wish to attend. The Selwyn activities persons meet five times a year and they attend workshops and support groups. They have been implementing a "Selwyn at home" programme in line with principles of the Eden way. The activities programme is developed with the residents and each resident also receives a copy of the monthly plan. The daily programme is written up on the dining room whiteboard and residents are notified if there are any changes to the programme. Activities are planned that are appropriate to the functional capabilities of residents. Residents are able to participate in bingo, exercise programmes, baking, craft groups, quiz and games, knitters group and Happy Hour. There is also reminiscing, music, art, entertainment, themed activities, visiting children’s groups, themed activities, visiting animals and a variety of activities to maintain strength and interests.

Social interaction is encouraged with other rest homes and a "round robin" activity is planned with other rest homes. There are weekly outings in the van. A dedicated outings driver with a first aid certificate accompanies the residents on trips.

The activity coordinator described providing regular one on one with those residents that don’t attend group activities. New activity programmes including “live” themes e.g. animal interaction, Invitational lunches. Gardening groups have been introduced. There are interdenominational church services and residents can attend their church in the weekends with transport arranged.

There is a range of cultural activities and celebrations including flax weaving and Chinese New Year.

Residents have an activities care plan with resident and family involvement.

D16.5d Monthly progress notes are written and six monthly evaluation is documented as occurring. A diversional therapy assessment documents a social history and previous interests and the care plan includes goals.

##### **Criterion 1.3.7.1 (HDS(C)S.2008:1.3.7.1)**

Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.3.8: Evaluation **(**HDS(C)S.2008:1.3.8)

Consumers' service delivery plans are evaluated in a comprehensive and timely manner.

ARC D16.3c; D16.3d; D16.4a ARHSS D16.3c; D16.4a

**Attainment and Risk:** FA

**Evidence:**

Three of six acute care needs support plans reviewed on the computer did not document when the issue/need was resolved or if transferred into the long term care plan.

There are three monthly reviews by the general practitioner (GP). The GP writes in Medtech but cuts and pastes into the system. Care plans are evaluated by the registered nurses six monthly or when changes to care occur in seven files sampled (one rest home and six hospital). Example: one file of a resident with weight loss/low appetite updated management strategies after a review by the dietitian. Risk assessment tools are also evaluated six monthly. This computer system is used for assessment and care plan review. Care reviews are posted to the family. Short term care plans are evaluated and discontinued when issues such as urinary tract infections, chest infections are resolved. This is an improvement since the previous audit.

##### **Criterion 1.3.8.2 (HDS(C)S.2008:1.3.8.2)**

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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.3.8.3 (HDS(C)S.2008:1.3.8.3)**

Where progress is different from expected, the service responds by initiating changes to the service delivery plan.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.3.12: Medicine Management **(**HDS(C)S.2008:1.3.12)

Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.

ARC D1.1g; D15.3c; D16.5e.i.2; D18.2; D19.2d ARHSS D1.1g; D15.3g; D16.5i..i.2; D18.2; D19.2d

**Attainment and Risk:** FA

**Evidence:**

Four of eighteen medication charts sampled have at least one regular dose of medication that has not been signed as administered.

Sarah Selwyn’s medication management system follows recognised standards and guidelines for safe medicine management in accordance with the guideline: Safe Management of Medicines, A Guide for Managers of Old People’s Homes and Residential Care Facilities and the Ministry of Health, Medicines Care Guide for Residential Aged Care 2011. The facility uses monthly supplied robotic sachet medication packs. Medications are checked on arrival by afternoon registered nurses.

Additional medications required are delivered and recorded as received. Alternative therapies are charted by the general practitioner (GP) and the pharmacy check for contraindications with other medications. Pharmacy signing sheets are generated with coloured sheets for groups of medicines e g pink for antibiotics.

All medications are kept in a locked trolley in a locked room. The registered nurses (RN) hold the keys. The medication fridge temperature is checked weekly. All medication in the fridges, drug trolleys and on shelves were sighted. There is glucagon in stock for diabetic emergencies. All opened eye drops were dated.

Fourteen resident medication charts were reviewed and all are identified with photographs and were current. All 14 signing sheets reviewed were correct and complete. This is an improvement since the previous audit. There is a list of staff with specimen signatures that have been assessed as being competent to administer medications. There is also a specimen GP signature list. Allergies and intolerances are recorded on the drug chart.

Controlled drugs are stored in a locked safe and a review of the controlled drug register shows all controlled drugs are checked by two people. Weekly controlled drug stock takes have been completed. The RN’s state that medication education takes place and this is conformed in staff training records.

There are no residents self-medicating at this time. There are guidelines for staff to use if this occurs.

Medication management audits occur three monthly. Medications and any changes are discussed with the resident or family/whanau where appropriate and documented in the progress notes. This was verified by checking progress notes.

Fourteen medication charts reviewed identified that the GP had seen the resident three monthly and the medication chart was reviewed and signed. GP’s fully write the reason the PRN medication is to be administered, on the medication chart.

##### **Criterion 1.3.12.1 (HDS(C)S.2008:1.3.12.1)**

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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.3.12.3 (HDS(C)S.2008:1.3.12.3)**

Service providers responsible for medicine management are competent to perform the function for each stage they manage.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.3.12.5 (HDS(C)S.2008:1.3.12.5)**

The facilitation of safe self-administration of medicines by consumers where appropriate.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.3.12.6 (HDS(C)S.2008:1.3.12.6)**

Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.3.13: Nutrition, Safe Food, And Fluid Management **(**HDS(C)S.2008:1.3.13)

A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.

ARC D1.1a; D15.2b; D19.2c; E3.3f ARHSS D1.1a; D15.2b; D15.2f; D19.2c

**Attainment and Risk:** FA

**Evidence:**

Food is prepared off site at Selwyn Villages' main centralised kitchen. Food service is contracted to an external provider. A four weekly rolling menu is implemented and changes seasonally. The main kitchen caters for all Selwyn Foundation sites the Village and Café.

D19.2 Advised by catering manager that 48 staff have completed NZQA unit standard 167 and seven catering assistants are in the process of completing this education module. The chefs have completed NZQA modules 167 and 168.

The service uses a four weekly rotating seasonal menu. Selwyn Aged Care Nutritional Analysis 2013, (dietitian review) dated February 2013 was sighted. A copy of residents nutritional profiles are sent to the main kitchen and also a copy is kept in the kitchen serveries on site. The kitchen has a comprehensive system whereby they are kept current with changing needs of the residents.

The food is transported to the facility in insulated hot boxes and transferred into bain maries. Food temperatures are taken before leaving the main kitchen and upon arrival and before service. The receiving kitchen also holds some food, sandwiches, biscuits, fruit and soup.

Residents are also given a choice e.g. alternate meat dishes and vegetarian. There is evidence of modified diets being provided e.g. diabetic menu and further nutritional supplements.

The service has a kitchen manual which includes (but not limited to); policies and procedures committed to the provision of nutritional foods; hydration needs, special dietary requirements and equipment, food safety and quality review. Fridge, food and freezer temperatures (main kitchen) are monitored twice daily and documented. Food in the chiller and freezer was covered and dated.

Sarah Selwyn kitchen/ serveries are spacious providing a safe working area and adequate dry storage and pantry area. All food storage items were off the floor. The kitchen area was very clean and tidy. Medirest staff carry out all cleaning duties. The hot meals are delivered from the main kitchen and held in the Bain Marie until served. Hot food and fridge temperature monitoring was sighted and all temperatures within acceptable limits. There are alternative fridges that can be used if there is a temperature problem. There are alternative foods available such as salads and nutritious snacks outside normal kitchen hours. Special/modified diets and additional supplements required are provided. Kitchen staff are aware of resident’s likes/dislikes and any changes are communicated to the staff. There are special items including: lip plates and easy grip utensils to meet the assessed needs of the rest home residents.

Residents can choose to have breakfast in bed or in the dining room. Staff were observed wearing correct protective clothing and safe footwear. The food service is a set agenda item at the residents meetings. There are six monthly food satisfaction surveys. Interviews with eight residents (two rest home and six hospital) overall spoke favourable about the food.

##### **Criterion 1.3.13.1 (HDS(C)S.2008:1.3.13.1)**

Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.3.13.2 (HDS(C)S.2008:1.3.13.2)**

Consumers who have additional or modified nutritional requirements or special diets have these needs met.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.3.13.5 (HDS(C)S.2008:1.3.13.5)**

All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

## **Outcome 1.4: Safe and Appropriate Environment**

Services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensures 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.

#### Standard 1.4.2: Facility Specifications **(**HDS(C)S.2008:1.4.2)

Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.

ARC D4.1b; D15.1; D15.2a; D15.2e; D15.3; D20.2; D20.3; D20.4; E3.2; E3.3e; E3.4a; E3.4c; E3.4d ARHSS D4.1c; D15.1; D15.2a; D15.2e; D15.2g; D15.3a; D15.3b; D15.3c; D15.3e; D15.3f; D15.3g; D15.3h; D15.3i; D20.2; D20.3; D20.4

**Attainment and Risk:** FA

**Evidence:**

Documentation and indicators considered during the audit and via sampling supports that the service is meeting the relevant requirements as identified by relevant legislation, standards and codes.

The building has two levels. The building holds a current warrant of fitness which expires on 18 June 2015. All electrical equipment is checked and tagged annually this has recently been completed. A process is in place for upgrading and replacing equipment as required. Fire drills occur six monthly.

##### **Criterion 1.4.2.1 (HDS(C)S.2008:1.4.2.1)**

All buildings, plant, and equipment comply with legislation.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.4.2.4 (HDS(C)S.2008:1.4.2.4)**

The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.4.2.6 (HDS(C)S.2008:1.4.2.6)**

Consumers are provided with safe and accessible external areas that meet their needs.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

# NZS 8134.2:2008: Health and Disability Services (Restraint Minimisation and Safe Practice) Standards

## **Outcome 2.1: Restraint Minimisation**

Services demonstrate that the use of restraint is actively minimised.

#### Standard 2.1.1: Restraint minimisation **(**HDS(RMSP)S.2008:2.1.1)

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

**Attainment and Risk:** FA

**Evidence:**

There is a restraint minimisation procedure. The procedure includes definitions of restraint and enablers, cultural safety, privacy and dignity, approved restraints, use of enablers and the role of the restraint co-ordinator; alternative interventions; external doors; implementing restraint; assessing risk; consent; monitoring; evaluation; quality review; education; related documents.

The restraint minimisation procedure states the purpose of restraint is 'To minimise the use of restraint while providing a safe environment for residents, staff and visitors. To ensure that when restraint is practised, it occurs in a safe and respectful manner for the minimum length of time'.

There are documented definitions for restraint and enablers.

The policy states that risks associated with restraint/enabler use will be identified, minimised and documented on the assessment and consent form.

All staff receive training in restraint minimisation at orientation and as part of the in-service training programme. The six monthly clinical compliance audits monitor each facilities' restraint use and over all compliance to the Selwyn Foundation Group philosophy. Definitions of restraint and enablers are congruent with the definition in NZS 8134. All residents have an assessment on entry which includes the need for a restraint of enabler.

The restraint co-ordinator interviewed was able to describe clearly the minimisation strategies used.

There are currently nine residents requiring restraints, no enablers are in use. The restraint minimisation procedure provides clear instructions for the management of restraint and enablers and these are being implemented.

##### **Criterion 2.1.1.4 (HDS(RMSP)S.2008:2.1.1.4)**

The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

# NZS 8134.3:2008: Health and Disability Services (Infection Prevention and Control) Standards

#### Standard 3.1: Infection control management **(**HDS(IPC)S.2008:3.1)

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.

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

There is an established and implemented infection control (IC) programme and its content and detail is appropriate for the size, complexity, and degree of risk associated with the service. The scope of the infection control programme is available. The service uses the Bug Control manual. There is a job description for the infection control coordinator and clearly defined guidelines. The infection control programme is linked into the risk management system.

The Selwyn organisation is responsible for the development of the infection control programme and its review. The programme is reviewed annually at an organisational level. The facility has access to professional advice within the organisation and has developed close links with the G.P's, labs, the infection control and public health departments at the local DHB and Bug Control. There are monthly infection control meetings that are part of the monthly staff /quality meeting. Minutes are available for staff.

The organisation is a member of Bug Control and accesses their resources for providing education to the infection control coordinators and for advice if required. Selwyn have a six monthly infection control coordinators meeting at head office chaired by the director of nursing. Data trending and analysis are discussed at the meeting

The facility has adequate signage at the entrance asking visitors not to enter if they have contracted or been in contact with infectious diseases. Communal toilets/bathrooms have hand hygiene notices in large print. There is a staff health SOP.

##### **Criterion 3.1.1 (HDS(IPC)S.2008:3.1.1)**

The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the organisation leading to the governing body and/or senior management.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 3.1.3 (HDS(IPC)S.2008:3.1.3)**

The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 3.1.9 (HDS(IPC)S.2008:3.1.9)**

Service providers and/or consumers and visitors suffering from, or exposed to and susceptible to, infectious diseases should be prevented from exposing others while infectious.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 3.5: Surveillance **(**HDS(IPC)S.2008:3.5)

Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.

**Attainment and Risk:** FA

**Evidence:**

Infection monitoring is the responsibility of the IC coordinator who is an RN. The infection control programme SOP describes routine monthly infection surveillance and reporting. Responsibilities and assignments are described and documented. The surveillance activities at Sarah Selwyn are appropriate to the acuity, risk and needs of the residents.

The IC coordinator collates IC data. The data is entered into the Selwyn database and the quality and education manager generates a monthly quality improvement report for each facility. Infection control data is benchmarked. The analysis is reported to the monthly staff / quality meetings (minutes viewed). The IC coordinator uses the information obtained through the surveillance of data to determine any extra infection control education needs within the facility

Internal audit of infection control is included three monthly in the annual programme. Definitions of infections are described in the infection control manual. Infection control SOP's are in place appropriate to the complexity of service provided. The surveillance SOP describes the purpose and methodology for the surveillance of infections including risk factors and needs of the consumers and service providers. Communication between the facility primary and secondary services regarding infection control is reportedly responsive and effective. GP's are notified if there is any resistance to antimicrobial agents. There is evidence of G.P involvement and laboratory reporting.

##### **Criterion 3.5.1 (HDS(IPC)S.2008:3.5.1)**

The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 3.5.7 (HDS(IPC)S.2008:3.5.7)**

Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*