

Selwyn Care Limited - Wilson Carlile House

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	Selwyn Care Limited	
Premises audited:	Wilson Carlile House	
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)	
Dates of audit:	Start date: 20 October 2014	End date: 21 October 2014
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:	51	

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

Selwyn Wilson Carlile is a purpose built facility that is part of a larger village. The facility provides care for up to 59 residents at rest home and hospital level care. Occupancy on the day of the audit was 51 residents, 30 at rest home level care and 21 residents at hospital level care.

The village manager, who oversees this village and two others, is a registered nurse with experience in the aged care sector and has been in the role for over three years. She is supported by an assistant village manager (registered nurse) and an assistant care lead (registered nurse) and a stable workforce. All residents and relatives interviewed spoke very highly about the care and support provided by staff and management.

The service has addressed one of the two shortfalls from their previous certification around aspects of medication. Improvements continue to be required around care planning interventions to support residents identified needs. This audit has not identified any further shortfalls.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The service has an open disclosure policy stating residents and/or their representatives have a right to full and frank information and open disclosure from service providers. There is a complaints policy and an incident/accident reporting policy. Family members are informed in a timely manner when their family members health status changes. The complaints process and forms for completion are available in the reception area. Brochures are also freely available for the Health and Disability and advocacy service with contact details provided. Information on how to make a complaint and the complaints process are included in the admission booklet and displayed throughout the facility.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Wilson Carlile has an established quality and risk management system that supports the provision of clinical care and support. Key components of the quality management system link to staff and facility meetings. 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 human resources standard operation procedures including recruitment, selection, orientation and staff training and development. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care 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 closely with staff input into rostering.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Registered nurses and the assistant care lead are responsible for each stage of service provision. Interdisciplinary assessment includes input from team members. Families interviewed are very supportive of the care provided.

There is sufficient information gained through the initial support plan, specific assessments, the short-term care plan, and most long term support plans to guide staff in the safe delivery of care to residents. There is an improvement required around aspects of care planning. There are short term care plans to focus on acute and short-term issues. Care plans are reviewed at least six monthly or when needs change.

An activities programme is provided that is flexible and meets the needs of the resident group.

Medications management was reviewed in each area and the main hospital treatment room. 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.

Safe and appropriate environment

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

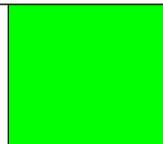


Standards applicable to this service fully attained.

The service has a current building warrant of fitness that expires on 1 December 2014.

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.

There is a restraint minimisation standard operation 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'. The service currently has two residents requiring restraint and no residents requiring enablers. Restraints in use are bed rails and lap belts.

Infection prevention and control

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

Standards applicable to this service fully attained.

The infection control 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

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	16	0	0	1	0	0
Criteria	0	41	0	0	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The complaints standard operating procedure (SOP) documents the responsibility of the assistant village 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. All complaints are documented including follow up letters and resolution demonstrates that complaints are well managed. Verbal complaints are also included and actions and response are documented. Discussion with six residents (four rest home and two hospital) and five family members (one rest home and four hospital) confirmed they were provided with information on complaints and complaints forms and all described having a concern addressed immediately. Eight written and one verbal complaints were reviewed for 2014. All were well documented including investigation, follow up letter and resolution.</p> <p>D13.3h: A complaints procedure is provided to residents and family members within the information pack at entry.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Accident/incidents management procedures alert staff around frank open disclosure and their responsibility to notify family/next of kin of any accident/incident that occurs.</p> <p>The two registered nurses interviewed stated that they record contact with family/whanau on the contact record. Contact records were 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. Ten incident forms (five rest home and five hospital) for August/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.</p> <p>A residents/relatives meeting occurs three monthly and issues arising from the meeting are fed back to staff meetings. Issues raised generate an investigation and quality improvement plan (QIP). There is an annual satisfaction survey (November 2013). Feedback from the survey indicated residents and family are satisfied with the service (89% satisfaction).</p> <p>There is a communication and interpreters services SOP. A list of language lines and government agencies is available. Access to DHB interpreter services is available.</p> <p>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</p> <p>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.</p> <p>D16.4b Five of five family members (one rest home and four hospital) stated that they are always informed when their family members health status changes.</p> <p>D11.3 The information pack is available in large print and advised that this can be read to residents if required.</p>
<p>Standard 1.2.1: Governance</p>	<p>FA</p>	<p>Selwyn Wilson Carlile is a purpose built facility that is part of a larger village. Selwyn has an overall mission statement "to deliver quality services that are</p>

<p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>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.</p> <p>The Selwyn Foundation is a charitable organisation that is governed by nine appointed board members. There is a chief executive officer who heads the organisations leadership team and he reports to the board. A leadership team chart with photos and job titles and a copy of the organisations strategic plan is given to residents and family members as part of the information pack on entry to the service.</p> <p>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. The village manager and the senior team at Wilson Carlile as part of her site specific annual plan, has set challenges, a vision and projects for 2014 resulting from the annual resident/relatives survey November 2013. Challenges include, communication with residents and families, improving the environment, improving the culture of caregivers and nursing staff to achieve an increase in residents satisfaction and teamwork, and to improve hospitality to residents. The vision for 2014 includes, providing quality care, development of regular communication with families by registered nurse case management and implementation of the “Household Model of Care”. The projects for 2014 include developing case management philosophy with registered nurses, restructuring of the roster and introduction of the “Household Model of Care”. The “Households Model of Care” includes residents in the rest home cared for in smaller groups with a lounge and dining area in each area and access to tea and coffee making facilities for residents. Consistent staff are also rostered to each group to improve communication and residents, families and staff satisfaction. There is a nurse’s station in each area.</p> <p>There is a nursing director to provide clinical leadership across the organisation. As well as facilitating six monthly meetings with all of the group infection control coordinators and restraint coordinator, she facilitates a two monthly meeting of the clinical coordinators, providing education and encouraging the sharing of best practice. Each facilities health and safety rep attends a six monthly organisational</p>
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		<p>health and safety meeting chaired by the quality and education manager.</p> <p>Selwyn has robust quality and risk management systems implemented across its facilities. Across all Selwyn facilities collated data including incidents/accidents, IC, complaints and restraint is analysed and benchmarked internally. Selwyn also benchmarks with another NZ provider.</p> <p>Wilson Carlile has an experienced village manager who is a registered nurse (RN) and has been in the role for three years. The village manager also oversees two other Selwyn facilities. She is supported by an assistant village manager (RN) recently appointed, who provides clinical oversight for all three facilities with considerable experience in aged care. The new assistant manager was attending orientation off site on the day of the audit. The village manager has previous DHB management experience and has a Master of Business Administration qualification in management. Selwyn Wilson Carlile has an assistant care lead RN who has been in the role for seven years. There are job descriptions for all three positions that include responsibilities and accountabilities.</p> <p>Selwyn provides a comprehensive orientation and training/support programme for their managers. Managers and clinical managers attend meetings and training at Group 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</p> <p>ARC,D17.3di (rest home), D17.4b (hospital): The village manager, assistant village manager and assistant care lead have maintained at least eight hours annually of professional development activities related to managing a rest home and hospital. The village manager has attended the Aged Care Conference 2013 and the RVA conference 2014. The clinical coordinator has attended a leadership programme 2014 and is currently completing post graduate studies.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>Wilson Carlile has a quality and risk system that is being implemented. The village manager is directly involved in operations at the facility as well as the new assistant village manager and the assistant care lead supporting her in this role. Interviews with four caregivers (one rest home and three rest home/hospital), two registered nurses and one clinical coordinator and review of meeting minutes demonstrate a culture of quality improvements. Quality and risk performance is reported across the facility meetings, through the communication book, and also to the</p>

	<p>organisation's management team. The service has standard operations procedures (SOP's) and associated implementation 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 group office level and feedback is gained at facility level. New or updated SOPs are available for staff to read and they sign having then read the new/updated document.</p> <p>Key components of the quality management system link to the monthly combined staff/quality/ IC/restraint and health and safety meetings. Each department provides quality reports on a monthly basis. Analysis and benchmarking information is discussed at monthly staff meetings and three monthly RN meetings. 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. Infection control rates, outbreaks and results of satisfaction surveys are reported to the care services team at staff meetings or sooner if required. A range of infection control internal audits are planned and undertaken three monthly throughout the year. Results are forwarded to the staff meetings.</p> <p>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.</p> <p>All facilities restraint coordinators meet six monthly at head office (20 August 2014). The meeting is chaired by the director of nursing. These meetings include a comprehensive review of restraint/enabler use. Restraint and enabler internal audits are completed three monthly (July 2014 with 100% compliance).</p> <p>There is a quality and risk management process being implemented at Wilson Carlile. Monitoring programme includes (but not limited to); cleaning, hot water,</p>
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		<p>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 quality and education manager. QIP's are investigated and corrective actions implemented in determined timelines. Reviews and closure of QIP's are documented. Selwyn is active in analysing data collected and QIP management. The service is currently addressing a QIPs regarding clinical compliance. The clinical nurse specialist completed the audit in August 2014 with 90% compliance. 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. QIPs are also generated from the organisation if required. The service completes annual satisfaction surveys for residents and families (November 2013) which is analysed by an external company. The service reports 89% satisfaction in November 2013 which has been reported back to the residents meetings in January/February 2014 with the goals/objectives for 2014 presented.</p> <p>There is a comprehensive health and safety/risk management programme in place. Hazard management SOP guides practice. There is a Selwyn health & safety plan.</p> <p>D19.3 There are implemented risk management and health and safety SOP's in place including accident and hazard management.</p> <p>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.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>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 with immediate action noted and any follow up action required. The data is linked to the organisation's benchmarking programme and this is used for comparative purposes. Minutes of the staff meeting reflect a discussion of</p>

		<p>results as sighted 10 September 2014 (27 staff attended and 9 October 2014 (19 staff attended).</p> <p>Ten incident forms (five rest home and five hospital) were reviewed across the service for August/September 2014 and all demonstrated clinical follow up by a registered nurse/clinical coordinator and monitoring (such as neurological observations) having been undertaken when indicated.</p> <p>D19.3c Selwyn has a standard operations procedure that describes responsibilities around reporting of a category one event. Discussions with service management, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications. Public health was notified promptly of the outbreak in April 2014.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>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. Six staff files reviewed (one clinical coordinator, one RN, one caregiver, one cook, one housekeeper and one diversional therapist), all had up to date performance appraisals.</p> <p>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. Completed orientation booklets are on staff files. Staff interviewed (four caregivers, two registered nurses, one diversional therapist and one cook) were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. One housekeeper file recently appointed evidence orientation has been conducted</p> <p>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. The service has compulsory training days throughout the year for core topics. An education database is maintained to facilitate the monitoring of this requirement by the Quality & Education Manager. The annual education schedule is being implemented. The director of nursing has developed core training packages in key areas including infection control and restraint. External education is available via the DHB. There is evidence on RN and the clinical coordinator staff files of external training. Discussion with staff and management confirmed that a comprehensive in-service</p>

		<p>training programme in relevant aspects of care and support is in place. Education is an agenda item of the monthly quality/staff meetings. Education is also provided for identified topics other than core training and these include but not limited to for 2014, communication and documentation, chemical safety, infection control, manual handling, first aid, fire drills, restraint, code of ethics for RNs, and an RN study day on care planning.</p> <p>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.</p> <p>D17.7d: There are implemented competencies for registered nurses related to specialised procedure or treatment including (but not limited to); medication, restraint and care planning.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. The service has recently restructured some of its staffing levels with the introduction of an assistant village manager and 20 more hours for caregiving. 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 village manager, assistant village manager or the assistant care lead, 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 assistant village manager with support from the assistant care lead covers the facility for the village manager during absences and holidays. The daily roster states that there are the following staff on each day: rest home am three caregivers, pm two caregivers, hospital am- one RN and five caregivers, pm - one RN and four caregivers, nights- one RN and two caregivers (rest home and hospital). A regional Selwyn physiotherapist provides physiotherapy services for the facility at least once a week. The registered nurses with support from the assistant care lead oversees the rest home.</p>

<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The service medication management system follows recognised standards and guidelines for safe medicine management practice 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.</p> <p>The facility uses monthly supplied robotic sachet medication packs. Medications are checked on arrival at the facility by the registered nurse and stored appropriately. The medication fridge (in the hospital treatment room) temperature is recorded daily.</p> <p>Ten resident medication charts were reviewed and all are identified with photographs and were current. All ten medication charts sampled have all medications signed for on the signing sheet. This was a previous audit finding that has now been addressed.</p> <p>Three monthly medication reviews for nine of 10 residents were documented on the prescription chart (one rest home resident has been at the service less than three months). There is a list of staff with specimen signatures that have been assessed as being competent to administer medications.</p> <p>Controlled drugs are stored appropriately and a review of the controlled drug register (two registers one for individual residents and one for stock drugs) shows all controlled drugs are checked by two people. Weekly controlled drug stock takes have occurred weekly. This was a previous audit finding that has now been addressed.</p> <p>There is a list of staff with specimen signatures that have been assessed as being competent to administer medications.</p> <p>All staff that administer medication are competent and have received medication management training. The clinical coordinator and two registered nurses interviewed were conversant with the service medicine management policies procedures.</p> <p>There is a self-medicating residents SOP available to guide staff practice if required. There are currently three residents self-administering medicines and all have a current competency assessment which have been reviewed three monthly. Medication training has been completed September 2014.</p> <p>Medication management audits occur three monthly (July 2014 with 100% compliance and planned for October 2014)). The service has in place SOP's for</p>
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		<p>ensuring all medicine related recording and documentation meets acceptable good practice standards. Medication and any changes are discussed with the resident or family/whanau where appropriate and documented in the progress notes. This was verified in resident and family interviews.</p> <p>Two registered nurses were observed safely and correctly administrating medications.</p> <p>D16.5.e.i.2; Nine of 10 medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed (one rest home resident has been at the service less than three months).</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>There is a large kitchen and all food is cooked on site. All staff working in the kitchen have food handling certificates. There are two cooks that work at the service one of whom is the kitchen coordinator and has worked at the service for 10 years. The kitchen includes one standalone fridge, one walk in cooler, one walk in freezer a gas hob and combi oven. The service prepares all food onsite and also prepares food for one of its other facilities. Food is served to the hospital residents directly from the main kitchen and food to the three rest home households is delivered in three portable bain maries. On admission the registered nurses complete a dietary profile and communicates individual resident's needs to the kitchen staff. This information is updated as required. Residents with special dietary needs have these needs reviewed as part of the six monthly care planning review process.</p> <p>There is a daily cleaning schedule in place. There is a comprehensive kitchen manual in place. The menu has been reviewed by a dietician October 2014. The menu is a rotational summer and winter menu.</p> <p>Review of the main kitchen noted that fridge and freezer temperatures are monitored daily and are within acceptable limits. Dish washer temperatures are also recorded daily. This audit noted that all food in the fridge and pantry is dated and labelled. Meat was noted to be stored correctly and the kitchen was very clean. Residents with special dietary needs have these needs assessed as part of the care planning process. Diets include soft, diabetic and one resident that prefers finger food (# link tracer hospital). Three of five care plans reviewed had eating and drinking assessed, and care plans reflected any special needs (# link 1.3.5.2).</p> <p>Six of six residents (four rest home and two hospital) interviewed and five families</p>

		<p>(five from the hospital and one from the rest home) report a high level of satisfaction with meals.</p> <p>D19.2 Kitchen staff have been trained in safe food handling at the compulsory study day October 2014.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	PA Moderate	<p>The previous audit identified that not all interventions were included in care plans.</p> <p>For this audit the sample of files reviewed included;</p> <p>Hospital - two files - one resident with a pressure area and one resident with breast cancer dementia and weight loss.</p> <p>Rest home - three files - one resident recently admitted, one resident who identifies as Maori and one resident with multiple comorbidities, deteriorating health and is a falls risk.</p> <p>Three (two rest home and one hospital) of five care plans sampled have identified needs fully addressed in the care plan. The previous shortfall continues to require improvement.</p> <p>D16.3k: Short term care plans are in use for changes in health status.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Selwyn Wilson Carlile 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 (# link 1.3.5.2). The care being provided is consistent with the needs of residents, this is evidenced by discussions with the four caregivers, five family (five from the hospital and one from the rest home), the clinical coordinator, two registered nurses and the village manager. There is a short-term care plan that is used for acute or short-term changes in health status.</p> <p>Five residents (three rest home and two hospital) files were sampled. Three (two rest home and one hospital) of five residents (four rest home and two hospital) had ADLs and nutrition well documented (# link 1.3.5.2). The progress notes all document that the RN has reviewed progress notes regularly and followed up any outstanding problems identified. Five of five files (three rest home and two hospital) sampled have all documents signed and dated.</p>

		<p>Turning charts and fluid balance charts were sighted for two residents. All were completed accurately and show appropriate care being provided.</p> <p>D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management.</p> <p>Specialist continence advice is available as needed and this could be described.</p> <p>Continence management in-services (core study days 2014) and wound management (September 2014) in-service have been provided.</p> <p>There are eight residents with wounds (four rest home and four hospital). Wounds include one debridement, one incision, and two leg ulcer (rest home) and one leg ulcer and three heel pressure areas (hospital). The heel pressure areas are one grade 1, one grade 2, and one grade 3. Two residents with long term chronic wounds are under the care of the wound nurse specialist. All wounds have documented assessment, treatment and evaluation.</p> <p>The registered nurses interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse.</p> <p>The GP interviewed reports confidence with the service. He is available during working hours and outside of working hours as confirmed by the GP and the clinical coordinator. The organisation also employs a nurse practitioner/nursing director who is available for advice.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The diversional therapist works Monday to Friday for a total of 32.5 hours each week and can be flexible with time over the weekend. The activities programme is developed by the diversional therapist and each resident receives a copy of the monthly plan. The plan is easy to read and colourful, it can be printed in large type to assist those residents with who are visually impaired.</p> <p>Activities are planned that are appropriate to the functional capabilities of residents. Residents are able to participate in indoor bowls, and an exercise programme. There is also reminiscing, crafts, music, art, entertainment, themed activities and a variety of activities to maintain strength and interests.</p>

		<p>D16.5d Monthly progress notes are written and six monthly evaluation is documented as occurring in this timeframe in four of five resident files reviewed (one rest home resident has been at the service less than six months). A diversional therapy assessment documents a social history and previous interests.</p> <p>Four of five files (two rest home and two hospital) sampled have a documented activities plan. One rest home resident has been at the service less than one month.</p> <p>Six residents (four rest home and two hospital) interviewed and five family (four from the hospital and one from the rest home) interviewed report that they are strongly consulted around activities and that the programme is constantly changed in response to resident and family feedback and suggestions. The previous certification audit reported improvements to the activity programme as a result of a satisfaction survey. The service continues to strive for improvement in the variety and delivery of the activities programme. The diversional therapist reports that she continues to work closely with residents and their families to develop an activities programme that meets the needs and interests of residents. The inter-rest home bowls competition continues and also the Christmas play (residents were practising for the play on the day of the audit. The play is planned to be performed for local school children, for other rest homes during the day and for friends and family. A group of school aged children from a local church continue to visit the service once a month on a Sunday and their Sunday school lesson is conducted with the residents observing and joining in. The diversional therapist has developed a plan where each month is themed. This involves families and staff in the wider activities programme. There is a team of volunteers that also assist with the programme and four of them were present on the day of the audit. Volunteers assist with the men's group, crafts group, travelling shop and visit individual residents. One volunteer speaks Swiss and is able to speak with one of the residents (# link hospital tracer). Community involvement includes a mothers group visiting, school visits, stroke club, local craft centres visits, church groups and girl guides visits. All six residents (four rest home and two hospital) interviewed and five family (five from the hospital and one from the rest home) interviewed report that they are strongly consulted around activities and that the programme is constantly changed in response to resident and family feedback and suggestion.</p>
Standard 1.3.8: Evaluation	FA	There is at least a one to three monthly review by the medical practitioner. Care plans are evaluated by the registered nurses six monthly or when changes to care

<p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>		<p>occur as sighted in four of five care plans sampled. One rest home resident has been at the service less than three months.</p> <p>There are short term care plans to focus on acute and short-term issues. Changes to the long term lifestyle care plan are made as required and at the six monthly review if required. From the sample group of resident's notes the short term care plans are well used and comprehensive.</p> <p>D16.4a Care plans are evaluated six monthly more frequently when clinically indicated (# link 1.3.5.2).</p> <p>D16.3c: All initial care plans were evaluated by the RN within three weeks of admission.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The service has a current building warrant of fitness that expires on 1 December 2014.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>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 Wilson Carlile are appropriate to the acuity, risk and needs of the residents.</p> <p>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</p> <p>Internal audit of infection control is included three monthly in the annual programme and was last conducted in September 2014. 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</p>

		<p>and effective. GP's are notified if there is any resistance to antimicrobial agents. There is evidence of G.P involvement and laboratory reporting. The service effectively managed a gastroenteritis outbreak in April 2014. Twenty six residents and 10 staff were affected. The outbreak started on 6 April 2014 and ended on 25 April 2014. Public Health was advised 6 April 2014 and appropriate records/log sheets were completed. Staff were kept informed daily and appropriate notices were placed at entrances for visitors. A notice was sent out to all families 7 April 2014.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>There 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.</p> <p>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.</p> <p>There are documented definitions for restraint and enablers.</p> <p>The policy states that risks associated with restraint/enabler use will be identified, minimised and documented on the assessment and consent form.</p> <p>All staff receive training in restraint minimisation at orientation and as part of the in-service training programme. The six monthly external 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. Restraint audit has been completed July 2014 and due in October 2014. Restraint minimisation education has been provided August 2014 and 17 staff and four registered nurses attended. Restraint competencies have been completed September 2014.</p> <p>The restraint co-ordinator interviewed was able to describe clearly the minimisation strategies used.</p> <p>There are currently two hospital residents requiring restraint. One resident has bedrails and a lap belt and another resident has bedrails. Assessment, consent,</p>

		<p>review, evaluation and monitoring are documented. Risks associated with restraint use are evident in both resident care plans. There are no residents using enablers. The restraint minimisation procedure provides clear instructions for the management of restraint and enablers. The caregivers interviewed could describe restraint and enablers and the philosophy around their use.</p>
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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA</p> <p>Moderate</p>	<p>Service delivery plans demonstrate service integration and demonstrate input from allied health including physiotherapy, speech therapist, GPs and podiatrist in five of five files sampled.</p> <p>Care plans are comprehensive and well written in three of the five files sampled (three from the rest home and two from the hospital).</p>	<p>Two (one rest home and one hospital) of five files sampled do not have interventions in the care plan relating to all areas of need (weight loss and pain management)</p>	<p>Ensure all identified areas of need are addressed in the care plan.</p> <p>60 days</p>

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

No data to display

End of the report.