

Selwyn Care Limited - Selwyn Heights

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:	Selwyn Heights Retirement Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 10 November 2014 End date: 10 November 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:	87

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
Yellow	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
Red	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 Heights is a purpose built facility that is part of a larger village and complex. The facility provides residential care for up to 102 residents at rest home and hospital level care. Occupancy on the day of the audit was 87 residents, 33 at rest home level care and 54 residents at hospital level care.

The Care Lead has been in the role for three months and is currently seconded to deliver InterRAI training for the service. The Group Residential Care manager is currently managing the facility. She is supported by an assistant village manager who has been in the role for three weeks and an assistant care lead who is a registered nurse and has been in the role for two years.

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 five year strategic plan. All residents and relatives interviewed spoke very highly about the care and support provided by staff and management.

The service has addressed two of the five shortfalls from the previous audit around aspects of care planning and chemical storage. Improvements continue to be required around aspects of quality improvement plans, corrective actions from incidents reports and care plan interventions.

This audit identified further improvements required around informed consent, aspects of quality reporting and aspects of medications.

Consumer rights

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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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 an improvement required around informed consent. 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

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Selwyn Heights has an established quality and risk management system. 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. There are improvements required around internal auditing reporting, quality improvement plans and incident actions reflected in care plans. There are standard operation procedures that describe the processes around human resources 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.

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Registered nurses and the assistant care lead are responsible for each stage of service provision. Resident assessments, care plans, progress notes, and medical/allied health notes are maintained 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.

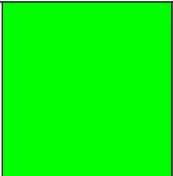
The service provides a comprehensive activity programme that involves residents in the community. The activity programme is focused on creating a regenerative community which is as home-like as possible, offering resident's relationships and

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 dietician. Changes to residents' dietary needs are communicated to the kitchen and special diets are noted.

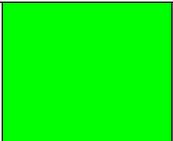
There is an improvement required around aspects of care planning, interventions and monitoring of self-medicating residents.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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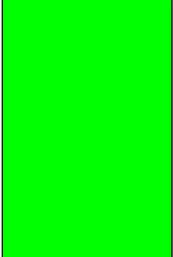
The rest home has a current building warrant of fitness that expires 13 April 2015. The hospital has a current warrant of fitness that expires 30 September 2015.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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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 nine residents requiring restraint and none using enablers.

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.
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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	15	0	0	4	0	0
Criteria	0	36	0	3	3	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 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	PA Moderate	Selwyn Heights has policies and procedures relating to informed consent and advanced directives. A review of six files identified that four of six files included signed informed consent forms to allow for taking of photographs, collecting health information and outings as part of the admission process and agreement. This is an area requiring improvement.
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	The complaints SOP (standard operations procedure) 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. 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 seven residents (two rest home and five hospital) and four hospital relatives confirmed they were provided with information on complaints and complaints forms and all

		<p>described having a concern addressed immediately.</p> <p>Complaints for 2013 included nine rest home and 24 hospital. Complaints for 2014 include seven rest home and 14 hospital (food, care, communication and emptying the vacuum cleaner). All were well documented including investigation; follow up letter and resolution within required timelines. There is one complaint received by the facility from the health and disability commissioner's office in March 2014 which has been resolved in May 2014 through the health and disability advocacy services.</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, 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.</p> <p>The two registered nurses, one enrolled nurse and one assistant care lead 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 (four rest home and six hospital) for October 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 NZ aged care provider.</p> <p>A residents/relatives meeting occurs monthly (one rest home and one hospital held 17 October 2014) 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 2014). Feedback from the survey indicated residents and family are satisfied with the service. (# link 1. 2.3.8).</p> <p>There is a communication and interpreters services SOP (standard operations procedure). 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</p>

		<p>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: Four hospital relatives members 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>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Selwyn Heights is a purpose built facility that is part of a larger village. The facility provides residential care for up to 102 residents at rest home and hospital level care. Occupancy on the day of the audit was 87 residents, (33 at rest home level care and 54 residents at hospital level care). There are currently no residents under the medical component of the contract. There is one rest home respite resident.</p> <p>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. 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 which is due for review November 2014. There is a Clinical Nurse Specialist 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 Care Leads and Assistant</p>

		<p>Care Leads, providing education and encouraging the sharing of best practice. Each facilities health and safety rep attends a six monthly organisational health and safety meeting chaired by the Organisation Performance and Development Manager (2 April 2014).</p> <p>Selwyn has robust quality and risk management systems implemented across its facilities (# 1.2.3.1, 1.2.3.6 and 1.2.3.8). 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>The care lead has been in the role for three months and has over three years previous management experience with the Selwyn Foundation. The care lead had been seconded on the day of the audit to train staff on InterRAI. The group Residential care manager is currently managing the facility with support from an assistant village manager (been in the role for three weeks and has a background working in aged care), an assistant care lead (RN) who has been in the role for over two years and a stable workforce. There are job descriptions for all positions that include responsibilities and accountabilities. The group residential care manager has considerable experience and has been employed by the Selwyn Foundation for over nine years. The Selwyn Foundation is undergoing a process of restructuring the organisation.</p> <p>Selwyn provides a comprehensive orientation and training/support programme for their managers. Managers (care leads) and clinical managers (assistant care leads) 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.</p> <p>ARC,D17.3di (rest home), D17.4b (hospital): The manager (care lead) and assistant care lead have maintained at least eight hours annually of professional development activities related to managing a rest home and hospital.</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>PA Moderate</p>	<p>Selwyn Heights has an established quality and risk system.</p> <p>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.</p>

	<p>Key components of the quality management system link to the monthly combined staff/quality/ IC/restraint and health and safety meetings (not evidenced in the general staff meeting since April 2014). Each department provides quality reports on a monthly basis. Analysis and benchmarking information is discussed at monthly staff meetings (prior to May 2014) and monthly RN meeting. 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 (evidenced prior to May 2014).</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 (2 April 2014). The meeting is chaired by the clinical nurse specialist. These meetings include a comprehensive review of restraint/enabler use. Restraint and enabler internal audits are completed three monthly (22 October 2014).</p> <p>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. This was a previous audit finding around internal audits still requires improvement.</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>
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<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 documents and analyses incidents/accidents, unplanned or unwanted events and provides feedback to the service and staff so that improvements are made (# link1.2.3.8). 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.</p> <p>Ten incident forms were reviewed across the service for October 2014 (four rest home and six hospital) and all demonstrated on the form clinical follow up by a registered nurse/assistant care lead and monitoring (such as neuro obs) having been undertaken when indicated. Two falls and four skin tears (hospital) and two falls, one wandering and one medication error (rest home) were reviewed. One rest home resident and one hospital resident with documented falls did not evidence updated falls interventions in the resident care plan. This was a previous audit finding (# link 1.3.6.1).</p> <p>D19.3c Selwyn has a standard operations procedure that describes responsibilities around reporting of a serious harm. Discussions with service management, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications.</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) and other health professionals including the GP, pharmacist and podiatrist.</p> <p>There are comprehensive human resources SOP's including recruitment, selection, orientation, staff training and development. Six staff files reviewed (one assistant care lead, two RN's, two caregivers and one activities assistant), all had up to date performance appraisals (one RN has evidence of a three monthly review following employment in July 2014).</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 (six caregivers, two RN's, one enrolled nurse, one assistant care lead, one diversional therapist and one activities assistant.), were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service.</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. At Selwyn Heights mandatory training occurs monthly with a set amount of staff participating. This process ensures all staff at the end of each year has attended mandatory training. The staff participation wall chart signed off for 2013/2014 and individual documentation in staff files viewed. The annual education schedule is being implemented. An education database has been developed to facilitate the monitoring of this requirement by the Organisation Performance and Development manager. 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, senior RN and the assistant care lead 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 quality/staff meetings. Education completed in 2014 includes but not limited to; manual handling, outbreak management, pain management, communication, documentation, health and safety, IPC, wound management, care planning and person centred training.</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 wound care.</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. 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 (currently group residential care 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 care lead covers the care lead (currently the</p>

		<p>group residential care manager) during absences and holidays. The daily roster states that there are the following staff on each day:</p> <p>Rest home: (which is in a separate building linked by an external corridor): am- one EN and four caregivers (an RN works during the weekend), pm two caregivers, nights- two caregivers.</p> <p>Hospital: am- assistant care lead, one senior RN, three RN's and 9 caregivers, pm - two RN's and six caregivers, nights- one RN and three caregivers.</p> <p>A regional Selwyn physiotherapist provides physiotherapy services for the facility at least twice weekly physio assistant works for two hours a day, five days a week in the hospital.</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>PA Moderate</p>	<p>Selwyn Heights 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.</p> <p>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.</p> <p>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.</p> <p>Twelve resident medication charts were reviewed and all are identified with photographs and were current. Ten of 12 signing sheets reviewed were correct and complete. There was no evidence of monitoring of the self-administration by two residents. The self-medicating residents have their medication stored in a locked drawer in their room. There is an improvement needed in the documentation of monitoring of self-administration. 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</p>

		<p>drug chart.</p> <p>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.</p> <p>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.</p> <p>D16.5.e.i.2; Eleven of 12 medication charts (one respite) 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 "as required" (PRN) medication is to be administered, on the medication chart.</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>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.</p> <p>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.</p> <p>The service uses a four weekly rotating seasonal menu. The menu has a dietician review prior to the seasonal menu change; the summer menu is due to commence in the Selwyn facilities within the next month. 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.</p> <p>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.</p> <p>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.</p>

		<p>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. Selwyn Heights 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. Kitchen catering 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.</p> <p>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 seven residents (two rest home and five hospital) overall spoke favourable about the food.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>The initial care plan is developed from the initial assessment and identifies the areas of concern or risk as evidenced in five of six files reviewed (# link 1.3.6.1). Resident comprehensive long term care plans are individually developed with the resident and/or family/whānau who sign to acknowledge their approval of the care plan. Seven residents and four family members interviewed stated they are involved in the care planning process. Nursing diagnosis, goals and outcomes are identified and agreed and how care is to be delivered is explained. The care plans are individualised for each resident. Each aspect of the care plan includes goals, interventions and assistance required and evaluations. This was a previous audit finding and improvements have been made in this area. (# link 1.3.6.1).</p>

<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Moderate</p>	<p>Selwyn Heights provides services for residents requiring rest home and hospital level of care. The care being provided is consistent with the needs of residents as evidenced in four of six files sampled. This was a previous audit finding that is still an area requiring improvement. 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. Six residents files were sampled (two rest home and four hospital),</p> <p>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.</p> <p>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 14 wounds, including four pressure areas (one grade 1, three grade 2). Photos are evident in wound folders and input from the nurse practitioner (NP) who is a wound specialist. The NP is on site four days a week. Dressing interventions are clear. Dressing evaluations are done each time and the time frame for the next dressing is specified. All wounds have documentation to evidence dressings are replaced within the stated time frame. Pressure area risk assessments are reviewed and interventions such as air alternating mattresses, roho cushions, booties and two hourly turns identified, documented and implemented, there is evidence of GP, dietician and NP input.</p> <p>Residents interviewed (five hospital, two rest home) report their needs are being appropriately met. Relatives interviewed (four hospital) state their relatives needs are being appropriately met and they are kept informed of any changes to health and interventions required. This is evidenced in the progress notes. When a resident's condition alters, the registered nurse initiates a review and if required a GP or NP visit.</p> <p>During the tour of facility it was observed that all staff treated residents with respect and dignity, knocked on doors before entering residents' rooms and ensured residents' dignity and privacy was protected when transferring residents to the shower or toilet. Residents interviewed were able to confirm that privacy and dignity was maintained.</p>
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<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 0830-1630, Monday to Friday. He has been in the role for three months and has worked in activities for two and a half years. There are two activities assistants that work Monday to Friday, the hospital assistant works 0900-1700 and has been at Selwyn Heights for 11 years, she has the Eden certificate and the ACE qualification. The rest home activities assistant works as a caregiver 0700-0900 and an activities assistant from 0900-1500. Both have considerable experience in the care of the elderly. There is a weekend volunteer who assists in carrying out the plan on the weekend. The facility has a full, varied and interesting programme, 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.</p> <p>The resident is assessed and with family involvement if applicable and likes, dislikes, hobbies etc. are discussed. A plan is developed and the resident is encouraged to join in activities that are appropriate and meaningful. There is an activities section in the resident file that includes an activities assessment, 'your life experiences', next of kin input into care and an activities plan. The plan includes categories for comfort and wellbeing, outings, interests and family and community links. Rest home and hospital residents mix and mingle as desired. One on one time is spent with residents who choose not to participate or who choose not to join in group activities.</p> <p>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.</p> <p>D16.5d Resident files reviewed identified that the individual activity plan is reviewed at care plan review.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>There is at least a three monthly review by the medical practitioner. Care plans are evaluated by the registered nurses six monthly or when changes to care occur. Example: one file of a resident with behaviours that challenge including updated management strategies for this resident in regards to wandering, verbal behaviour and physical behaviour.</p> <p>There is evidence of changes to the long term lifestyle care plan as required and at the six monthly review. Short term care plans are in use for changes in health status and include interventions and date of resolution. Examples sighted are cares required for wounds, respiratory tract infections, thrush.</p> <p>D16.4a Care plans are evaluated six monthly more frequently when clinically indicated.</p> <p>ARC: D16.3c: Five of six initial care plans were evaluated by the RN within three weeks of admission (one resident is on respite care).</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>Chemicals were evidenced stored securely in locked cleaning cupboards and locked cupboards in the laundry. This was a previous audit finding that has now been addressed.</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 rest home has a current building warrant of fitness that expires 13 April 2015.</p> <p>The hospital has a current warrant of fitness that expires 30 September 2015</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 Selwyn Heights 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 Operations analyst generates a monthly quality improvement report for each</p>

		<p>facility. Infection control data is benchmarked. The analysis is reported to the monthly staff (# link 1.2.3.6)/ 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 and effective. GP's are notified if there is any resistance to antimicrobial agents. There is evidence of G.P involvement and laboratory reporting. There have been no outbreaks at the service during 2013/2014. The IC coordinator attended the group IC meeting 20 March 2014 and discussion on surveillance was documented.</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>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.</p> <p>The restraint co-ordinator interviewed was able to describe clearly the minimisation strategies used.</p> <p>There are currently nine residents requiring the use of 11 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</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.10.4</p> <p>The service is able to demonstrate that written consent is obtained where required.</p>	PA Moderate	Selwyn Heights has policies and procedures relating to informed consent and advanced directives. A review of six files identified that four of six files included signed informed consent forms to allow for taking of photographs, collecting health information and outings as part of the admission process and agreement.	Four of six files reviewed did not have evidence of written consent being obtained when they were admitted from a different Selwyn facility after a change in care level, one in 2009 and the other in 2012.	<p>Ensure that documentation to support consents is obtained for all residents on the day of admission as per policy.</p> <p>30 days</p>
<p>Criterion 1.2.3.1</p> <p>The organisation has a quality and risk management system which is understood and implemented by service providers.</p>	PA Low	There is an established quality and risk management system. The 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 are entered	There have been no audits completed in October as per the audit schedule.	<p>Ensure that all audits are completed as per the audit schedule.</p> <p>90 days</p>

		into the database.		
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	Quality and risk performance is reported across the facility meetings, through the communication book, and also to the organisation's management team	There is no documented evidence that quality data is reported to staff at the general staff meeting since April 2014.	<p>Ensure that all quality data is reported to all staff at the facility meetings and that this is documented.</p> <p>90 days</p>
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Moderate	Audit summaries are entered into the database. 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.	Clinical audits completed in May and August 2014 with 93% compliance, cleaning audits completed in August and September 2014 with 93% and 83 % compliance and the annual satisfaction survey in November 2013 do not show evidence of corrective actions developed as a result of shortfalls identified.	<p>Ensure that corrective actions are developed for areas of audits/surveys that have not reached compliance.</p> <p>30 days</p>
<p>Criterion 1.3.12.5</p> <p>The facilitation of safe self-administration of medicines by consumers where appropriate.</p>	PA Low	Policy states that self-medication must be monitored every shift.	Two of two self-medicating residents had no documentation to evidence they had been monitored	<p>Ensure that all self-medicating residents have self-medication monitored and that this is documented every shift.</p> <p>30 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the</p>	PA Moderate	Selwyn Heights provides services for residents requiring rest home and hospital level of care. The care being provided is consistent with the needs of residents as evidenced in four of six	(i)One resident in the hospital (tracer) had changes in weight and neither the dietician, GP or Nurse Practitioner were notified when the weight dropped in three weeks. (ii)Two residents with a fall documented on an incident form had no	(i), (ii), (iii) ensure that all residents have documented assessments, care plans and interventions to meet the resident health needs

<p>consumers' assessed needs, and desired outcomes.</p>		<p>files sampled.</p>	<p>clear interventions in relation to falls prevention on their care plan (this remains an issue since previous audit) (iii) One rest home respite resident had no assessments or an initial care plan completed.</p>	<p>documented. 30 days</p>
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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.