

Selwyn Care Limited - Selwyn Oaks

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 Oaks

Services audited: Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

Dates of audit: Start date: 26 November 2014 End date: 26 November 2014

Proposed changes to current services (if any): An additional two hospital level beds were approved in August 2013. The service requests these beds be approved for dual service. The service is meeting the requirements for rest home/hospital level of care.

Total beds occupied across all premises included in the audit on the first day of the audit: 65

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 Oaks is a purpose built facility that provides residential care for up to 66 residents at rest home and hospital level care. Occupancy on the day of the audit was 65 residents, 28 at rest home level care and 37 residents at hospital level care. This audit has assessed two previously hospital only beds as suitable for rest home or hospital level residents.

Selwyn Oaks has a village manager who has been in the role for four months and has experience in management, finance and human resources. He is supported by an experienced care lead/registered nurse who has been in the role eight years. There is management support provided by group office. All residents and relatives interviewed spoke very highly about the care and support provided by staff and management.

Three of three shortfalls from the previous certification audit regarding care plans, transcribing and maintenance have been addressed. This audit identified improvement is required around medication documentation and prescribed nutritional supplements.

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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Selwyn's mission statement reflects the Selwyn Oaks' objective to deliver services that are responsive to the ageing person and their family. Policies are implemented to support rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the code of rights and services is readily available to residents and families. Complaints processes are implemented and complaints and concerns are managed and documented. Open disclosure is practiced and this is verified by residents and family interviewed.

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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Selwyn Oaks has a site specific business plan and goals. There is an established quality and risk management system that supports the provision of clinical care and support. Key components of the quality management system link into quality and staff 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 human resources standard operation procedures including recruitment, selection, orientation and staff training and development. Staff, residents and relatives confirm there are adequate staffing levels.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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Selwyn Oaks is implementing the Eden Philosophy and this is documented throughout care plans for the residents. Nursing care plans reviewed were individualised, accurate and up to date. Care plans are goal oriented and reviewed at least six monthly.

Activities provided for residents are varied, age appropriate and include inclusion at local community and entertainment events.

The medication management system is appropriate. Staff responsible for medication administration are trained and monitored. Medications are reviewed by the residents' general practitioner at least three monthly. Individual resident's medication charts were sighted. The menu is designed and reviewed by a registered dietitian employed by the contracted food service. Residents have a nutritional profile developed on admission which is reviewed six monthly as part of the care plan review. Residents were complimentary about the meals.

The previous audit findings around care plan documentation and medication transcribing have been addressed.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building has a current warrant of fitness. There was adequate resident and clinical equipment available on the day of audit. Previous findings around maintenance and repairs have been addressed. The two previously hospital only rooms assessed in this audit are suitable for either rest home or hospital use.

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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There is a restraint minimisation standard operation procedure. The procedure includes definitions of restraint and enablers which is congruent with the definition in NZS 8134. The service has a restraint co-ordinator (registered nurse) with defined responsibilities. There were two residents with restraints and one resident with an enabler. Clinical staff attend restraint education.

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 programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. 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	1	0	0	0
Criteria	0	39	0	1	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
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>Complaints information is provided at entry to the service and is readily available to residents and complies with right 10 of the Code. Residents/family/whanau were supported to discuss the complaint process. The village manager is responsible for ensuring all complaints (verbal and written) are investigated and followed up as per the standard operating procedure for complaints. The care lead (RN) completes initial investigations for all clinical/care concerns and complaints. The complaints register was up to date and recorded the details of the complaint date of corrective actions taken and signed off when resolved. Six complaints during 2014 have been received and all have been documented including follow up letters and resolution that demonstrates that complaints are well managed internally. A record of all complaints per month is entered into the Selwyn database. The number of complaints received each month is reported monthly to care services via the facility benchmarking report. Complaints were discussed at the monthly RN forum, combined quality/ staff meetings and at organizational level. Complaints were also linked to the quality management system and several improvements to the service have occurred such as improvements in the food services.</p> <p>D13.3h: A complaints procedure was provided to residents 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>There is an open disclosure policy that includes information on the residents or their representative right to full and open disclosure. Incident and accident forms were completed by the registered nurses (RNs). Incident/accident forms sighted evidence the family has been notified. Family notification is also recorded on the personal and telephone conversation record held in the resident file. Family interviewed (two rest home and three hospital) confirmed they are kept informed of their relatives health status and notified of any incidents/accidents. The village manager and care lead (RN) have an open door policy. Resident meetings are held monthly and any issues raised are addressed and fed back to the residents at the next meeting. The residents and families have an opportunity to provide feedback on the service through the annual resident/relative survey. The company engaged an external contractor to collate the results and measure Selwyn Foundation performance against international facilities of similar size. Selwyn Oaks performed top of the Selwyn facilities for 2014.</p> <p>There is an interpreter policy in place with access to district health board interpreter service.</p> <p>D12.1 Non-Subsidised residents are advised of the process and eligibility to become a subsidized resident through the admission booklet.</p> <p>D16.4b Residents (two rest home) and families (five) interviewed confirmed they are kept fully informed.</p> <p>D11.3 The admission booklet is available in large print and 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 Oaks is one of 10 facilities in the Selwyn Foundation group. The Selwyn Foundation is a charitable trust governed by appointed board members. The chief executive leads the organizational teams and report to the board. The village manager attends monthly management meetings at head office. A company clinical nurse specialist/nurse practitioner meets with clinical managers/care lead RNs two monthly.</p> <p>The purpose, values, scope, direction, and goals of the Selwyn Foundation are clearly identified in the business plan for 2014. Selwyn Oaks site specific 2014 business and quality risk plan aligns with the company strategic plan.</p> <p>Selwyn Oaks provides care for up to 66 residents at rest home or hospital level of care. The occupancy on the day of audit was at 65. The facility is divided into wings for rest home or hospital level. There is one wing of 12 dual purpose beds (two additional dual purpose beds were approved in August 2013 and have been</p>

		<p>assessed as suitable during this audit).</p> <p>The village manager (non-clinical) has been in the role for four months. He has a background in the management of acute care facilities, human resource and financial management. He is responsible for the support services and oversees the village. The village manager reports directly to the general manager. The care lead/RN has been in the role at Selwyn Oaks for eight years and has an extensive clinical experience in aged care including palliative care and education. The care lead is responsible for the clinical services and education.</p> <p>ARC,D17.3di: (rest home), D17.4b (hospital): The manager and care lead/RN 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>FA</p>	<p>Selwyn Oaks has a site specific 2014 business plan and a quality and risk management plan in place that is a “working” document with evidence the goals are regularly reviewed (document sighted).</p> <p>Goals identified for 2014 are as follows;</p> <ol style="list-style-type: none"> 1. Develop chaplaincy services to meet the spiritual needs of the residents and provide a private space for worship. A private area has been set aside for worship. The chaplain provides a monthly report to the manager. Spiritual needs of the residents are being met. 2. Employment of a qualified diversional therapist (DT) to enhance the activity programme. The service has recently recruited a DT due to commence mid-January 2015. 3. A new education/teaching programme that is standardised across all the facilities. The care lead/RN has written some of the programme for the organisation and is involved in training the trainers. All staff are now rostered to attend an eight hour session that covers mandatory and person centred care education. 4. Provision of a 20 week literacy programme aimed at improving staff confidence, documentation and communication with residents, family and staff. The service has 80% of their staff with English as their second language or literacy problems. Eleven of 35 staff registered on the programme have graduated with a positive flow on effect to the residents and increased confidence in the staff. <p>A range of quality data was collated, analysed and evaluated including infections summary/surveillance, incidents/accidents, complaints, surveys, restraint register and internal audits. Quality reports are provided on a monthly basis. Monthly</p>

	<p>accident/incident data is entered into the Selwyn data base. Internal benchmarking occurs with other facilities of similar size within the Selwyn Foundation. Analysis and benchmarking information is discussed at monthly quality/staff meetings and monthly RN forums. Staff interviewed confirmed quality data is made available to them and discussed at the meetings. One quality goal for 2015 identified from collation of recent data is to reduce the incidence of bruising occurring due the increase in the frailty and acuity of residents.</p> <p>There is a 2014 internal audit programme in place that covers all areas of service delivery. Monthly audits are delegated to key people for completion. Audit summaries and action plans are completed in consultation with the auditor where a noncompliance is identified. Issues and scores are entered into the database. Any audit that scores less than 100% has a quality improvement plan (QIP) generated by the lead care/RN. QIP's are investigated and corrective actions implemented in determined timelines. Reviews and closure of QIP's are documented. Audit outcomes and quality initiatives are discussed at meetings. Previous matters are followed up and outcomes documented in minutes. Benchmarking reports are generated throughout the year to review performance over a 12 month period. Quality improvements are raised where there is an identified short fall in any area of the quality risk management system.</p> <p>D19.3 There is a comprehensive health and safety risk management plan in place that identifies actual and potential risks. Hazard management standard operating procedures (SOP) guides practice. The service has a health and safety (H&S) representative who has completed stage one of H&S training. The H&S representative reports to quality/staff meeting monthly and to the H&S officer at head office. Company H&S representatives meet six monthly. Monthly H&S audits are completed. Concerns and corrective actions are reported to the village manager. Hazards are reported. Each area has a current hazard register.</p> <p>D19.2g: Fall prevention strategies include SOP for falls prevention, accident/incident analysis and the identification of interventions on a case by case basis to minimise future falls. Interventions include ultra-low beds, sensor mats and wearing of hip protectors.</p> <p>D5.4 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. There is an annual staff training program that is implemented and based around policies and</p>
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		procedures. Staff are required to read and sign they have read new/reviewed SOP's.
<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>	FA	<p>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. The RN completes incident/accident forms for resident related events, completes clinical assessment and documentation and notifies the family. The care lead/RN ensures corrective action/interventions are implemented. The village manager ensures all non-clinical accidents/incidents and unwanted events are investigated 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 quality/staff meeting reflect a discussion of accident/incident data.</p> <p>D19.3d: The service is aware that they will inform the DHB of any serious accidents or incidents. Discussions with the care lead/RN confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. A critical care summary form has been developed to be completed for all serious events including outbreaks. The critical care summary form is emailed/faxed to the group services manager (RN) who is responsible for notifying the DHB and any other relevant authorities.</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>	FA	<p>There are comprehensive human resources SOP's including recruitment, selection, orientation, staff training and development. A copy of RN practicing certificates was kept on the staff files. Five staff files were sampled. All staff files contained signed job descriptions, reference checks, police vetting (where relevant), and current performance appraisal and education certificates. All RNs, night duty staff, activities staff and maintenance person complete first aid.</p> <p>There is a comprehensive orientation program that provides new staff with relevant information for safe work practice. Files reviewed evidenced that RNs and caregivers had completed the orientation program. The recently developed standardised education programme has commenced with eight hour study days incorporating mandatory training and person centred care education. Specialist training such as</p>

		<p>restraint, manual handling, emergency response, fire drill, first aid, infection control is delivered separately. All training sessions are evaluated with validation of learning recorded. RNs attend external training offered such as gerontology and relevant DHB education. There are two aged care education (ACE) assessors on site. Care staff have commenced the dementia course. An assessor is allocated two days a week to work with the students and mark papers. 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. Core competencies are completed annually and a record of completion is maintained - signed competency questionnaires sighted in reviewed files included infection control, food safety and hoist.</p> <p>D17.8.The annual training program well exceeds eight hours annually.</p> <p>17.7d: There are implemented competencies for registered nurses related to specialised procedure or treatment including (but not limited to); medication, wound and restraint.</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. Staff interviewed (four caregivers and one RN) 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 or the care lead/RN clinical will be on-call at all times.</p> <p>There are two RNs on morning and afternoon shifts seven days/week. One is based in the rest home and dual service wing. The second RN is based in the hospital wing. There is one RN with three care staff on night duty. The RN covers the hospital wing and dual service wing which are closely located.</p> <p>Care staff do not provide any cares to village residents. Two care staff (who hold a first aid certificate) respond to village call bells after hours. The facility remains adequately staffed when care staff are attending to the calls. These standards are evident on review of the weekly rosters and discussions with staff. The care lead covers the facility manager during absences and holidays. The daily roster states that there are the following care staff on each day: am- nine caregivers, pm - six caregivers, nights- three caregivers. There are dedicated housekeeping staff. Sickness and annual leave is covered by staff through the Selwyn pool of relief staff.</p>
<p>Standard 1.3.12: Medicine Management</p>	<p>PA Low</p>	<p>The four weekly Robotic dispensing system is used at Selwyn Oaks. Fourteen</p>

<p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>medication charts reviewed identified photo ID's, allergies recorded, signing on administration by staff and GP prescribing is legible and correct. Policies and protocols are in place to manage the safe and appropriate prescribing, dispensing, administration, review, storage and disposal of medicines in order to comply with legislation, regulations and guidelines.</p> <p>There is a contract with the pharmacy. Robotic pack medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy.</p> <p>Medications are kept in a locked medication trolley in a locked dispensary. Staff sign for the administration of medications on medication sheets held with the medicines. There is a list of specimen signatures and competencies. Medications are reviewed by the GP at least three monthly. On two of 12 medication charts reviewed two evidenced no PRN indication for use.</p> <p>All registered nurses' administering medications have completed medication competencies (sighted).</p> <p>The previous audit found that transcribing was an area for improvement. This has been rectified</p> <p>Signing for prescribed fortified supplements and the prescriber documenting indications for use with PRN medications are areas for improvement.</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 are food policies/procedures for food services and menu planning appropriate for this type of service.</p> <p>All meals are cooked on site by a contracted provider. A four weekly rolling menu is implemented and changes seasonally four times a year. The menu is developed and reviewed by a dietician. All kitchen staff completed food handling certificates.</p> <p>Fridge, food and freezer temperatures in the main kitchen are monitored daily. Food in the chillers was covered and dated.</p> <p>Residents with special dietary needs have these needs identified their care plans and these needs are reviewed six monthly as part of the care planning review process. Dietary information and changes are sent to the main kitchen and also retained in the receiving kitchen. Resident likes and dislikes are known and alternatives foods provided. A review of resident files evidenced that monthly weights are undertaken and weight managed were needed.</p> <p>Observation of lunch time evidenced that the meal time is calm with staff assisting residents with their meals as needed. Residents and families interviewed confirmed</p>

		satisfaction with the food services.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	The previous audit evidenced that care plan documentation was an area for improvement. This audit found all six care plans (three rest home and three hospital) reflected RN assessments and resident needs.
<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>The service is adopting the Eden Alternative philosophy. Interviews with four caregivers and registered nurse and quality meeting minutes sighted evidence that this philosophy is well integrated.</p> <p>Care delivery is recorded in the progress notes at least daily by the care givers as evidenced in all six residents' files sighted). Six resident files documented that RNs followed-up on issues raised. The four caregivers interviewed stated that they have all the equipment referred to in care plans and necessary to provide care.</p> <p>Staff report that there are always adequate continence supplies and dressing supplies. On the day of the audit, plentiful supplies of these products were sighted. Five families interviewed were complimentary of the care at the facility.</p> <p>Six care plans reviewed documented that activities of daily living, links with allied health, GP and management of behaviour are well documented. Family communication and involvement in care is documented and all five families stated they are very much involved. The care being provided is consistent with the needs of residents and this is evidenced in discussions with four caregivers, and five families interviewed.</p> <p>Auditor observation evidenced that the care givers provide a high standard of care. They demonstrated a caring and calm approach to the residents. There is a short-term care plan that is used for acute or short-term changes in health status. It was noted through quality meeting meetings that the service is addressing an identified concern around integration of short term care plans in the resident file.</p> <p>Three wounds were sampled. All three had assessments, dressing plans, two with photos and all had evaluations. Two were skin tears. All had an associated short term care plan.</p>
<p>Standard 1.3.7: Planned Activities</p>	FA	The activity monthly calendar evidenced varied activities suited to both rest home and hospital level residents' over seven days. Selwyn Oaks has appointed a new

<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>diversional therapist, who is due to start mid-January 2015. The activities are currently managed by two caregivers, one who works three days a week, the other two days. One activities assistant interviewed has ACE level three and level four, dementia qualifications.</p> <p>Selwyn Oaks, as part of the Eden philosophy considers that activities are integral to the daily life of residents. The involvement of all staff including care givers enables the facility to provide an individualised programme according to the resident need at any given time. The care givers provide activities to the residents with an extra care giver on each shift to assist with activities and involvement of volunteers. Activities are supervised and led by the registered diversional therapist employed at Selwyn Oaks. A variety of activities are provided that also reflect normal patterns of life and community contact. On the day of audit, residents in all areas were observed being actively involved with a variety of activities. There is an over-arching activities programme is developed monthly. On the day of audit the musical entertainers played to some hospital residents in their rooms after the main concert. There was also documented evidence of one on one visits completed by the activities assistant in the hospital wings</p> <p>Residents have a lifestyle assessment and questionnaire completed in the first few weeks of admission. The lifestyle assessment is in the resident file to assist care givers with providing meaningful activities to residents.</p> <p>D16.5d: Individual activity plans are reviewed at the time of residents long term care plan review.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Support plans are reviewed and evaluated by the registered nurse at least six monthly or when changes to care occur. There is at least a one- three monthly review by the medical practitioner. This was evidenced in six care plans reviewed.</p> <p>There are short-term care plans to focus on acute and short-term issues. Behaviour monitoring was in place for one resident and this is monitored through progress notes and behaviour monitoring forms. The RN evaluations are documented and include a review of behaviour and interventions.</p> <p>D16.4a: Care plans are evaluated six monthly more frequently when clinically indicated.</p>
<p>Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate,</p>	<p>FA</p>	<p>The building holds a current warrant of fitness which expires on 26 March 2015. Adequate resident and clinical equipment was observed throughout the facility on the day of audit including (but not limited to); electric beds, pressure relieving resources,</p>

<p>accessible physical environment and facilities that are fit for their purpose.</p>		<p>hoists, hospital lounge chairs, shower chairs and mobility aids. The previous audit finding around repairs and maintenance has been addressed. The two rooms being assessed as suitable for rest home or hospital residents in this audit are suitable to meet the needs of either client group.</p>
<p>Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Infection control (IC) monitoring is the responsibility of the infection control (IC), a registered nurse based in the hospital. The infection control policy describes routine monthly infection surveillance and reporting. Responsibilities and assignments are described and documented. The surveillance activities at Selwyn Oaks are appropriate to the acuity, risk and needs of the residents.</p> <p>The monthly analysis is reported to the monthly RN forum/ staff and monthly quality meetings that include a cross section of staff. The IC coordinator uses the information obtained through the surveillance of data to determine infection control education needs and quality initiatives.</p> <p>The surveillance policy describes the purpose and methodology for the surveillance of infections including risk factors and needs of the consumers and service providers. . GP's are notified if there is any resistance to antimicrobial agents. There is evidence of GP involvement and laboratory reporting. Benchmarking occurs with other facilities within the Selwyn group.</p>
<p>Standard 2.1.1: Restraint minimisation 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 that is congruent with the definition in NZS 8134. The restraint coordinator is an RN based in the hospital wing that has been in the role for 12 months. She has defined responsibilities as outlined in the job description dated March 2014. There are two residents with restraints (bedrails) and one resident with an enabler (lap belt). Assessments, consents and evaluations are completed involving the restraint coordinator, care lead/RN, GP and resident/family. There is a nursing care plan for bedrails in the files of the two residents with restraint. The care plan includes risks identified with the use of restraint and monitoring requirements. The restraint co-ordinator attends a restraint meeting and study day with the clinical nurse specialist every six months. All clinical staff attend restraint education. The caregivers interviewed could describe restraint and enablers and the philosophy around their use.</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 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	PA Low	Medication charts are written and signed by the GP. There are appropriate policies and procedures in place to guide staff with all aspects of medication management.	<p>1) Two of 12 medication charts reviewed evidenced no prescribed indication for use for as required medication. 2) Prescribed fortified supplements are not signed for on signing sheets.</p>	<p>1) Ensure that PRN medication includes indications for use. 2) Ensure fortified supplements are signed for as prescribed.</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.