

Selwyn Care Limited - Kerridge House

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Selwyn Care Limited
Premises audited:	Kerridge House
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 23 April 2015 End date: 24 April 2015
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:	57

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

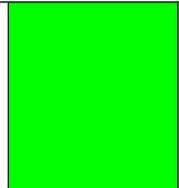
Kerridge House is owned and operated by the Selwyn Foundation. The service provides care for up to 59 residents. On the day of audit there were 57 residents. The care lead was appointed two months ago and has 10 years aged care experience. He is supported by an assistant village manager and clinical nurse specialist.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the District Health Board. This audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management and staff

The service has continued to implement a number of quality improvements. The previous certification and partial provisional audits did not identify any shortfalls.

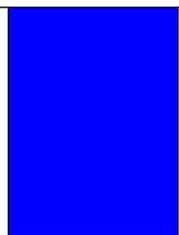
This audit identified an improvement required around the discontinuation of medications. The service has continues to exceed the standard around governance, quality and risk management and activities.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The service practices open communication with residents and families and concerns have been managed and a complaints register is maintained. There is documented evidence of relative notification for any changes in health status.

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.		All standards applicable to this service fully attained with some standards exceeded.
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Kerridge House has a quality and risk management system in place that is implemented and monitored, which generates improvements in practice and service delivery. Key components of the quality management system link to relevant facility meetings. The service is active in analysing data with recent evidence of benchmarking outcomes with other similar aged care facilities. Corrective actions are identified and implemented. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and appropriately managed. There is a comprehensive orientation programme that provides new staff with relevant and specific information for safe work practice. The in-service education programme covers relevant aspects of care and support. The staffing levels provide sufficient and appropriate coverage for the effective delivery of rest home and hospital level of care. Staffing is based on the occupancy and acuity of the residents.

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 low risk.</p>
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Assessments, care plans and evaluations are completed by the registered nurses. Residents/relatives/whanau are involved in planning and evaluating care. Care plans demonstrate service integration and are individualised to meet the resident's needs. Care plans are evaluated six monthly or more frequently when clinically indicated. Short term care plans are available for use for short term needs. Residents and family interviewed were very complimentary about the care received.

The activity coordinator and Selwyn Village diversional therapist provide a seven day week programme focused on meaningful activities that meet the individual abilities and recreational preferences. Community links are maintained. The service has a group of volunteers involved in the activity programme.

The service medication management standard operating procedures follow recognised standards and guidelines for safe medicine management. The general practitioner reviews medication charts three monthly.

Meals are prepared and cooked off-site by contractors. Individual and special dietary needs are accommodated.

Safe and appropriate environment

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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The building holds a current warrant of fitness.

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 policy that included comprehensive restraint procedures and aligns with the standards. There were no residents using enablers and two residents with restraints. The service complies with restraint policy and required documentation was in place. Staff receive ongoing 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, is appropriate for the size, complexity, and degree of risk associated with the service. The service has an Infection control co-ordinator with defined responsibilities. Reports and surveillance data are discussed at staff meetings. Results of surveillance are acted upon, evaluated and reported to relevant personnel.

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	3	12	0	1	0	0	0
Criteria	4	34	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>	FA	<p>A complaints policy and procedures have been implemented and residents and their family/whanau have been provided with information on admission. Complaint forms are available at the service. Residents interviewed confirm they received information on the complaints process on admission and the care lead is very approachable should they have any concerns/complaints. Staff (four caregivers) interviewed are aware of the complaints process and to whom they should direct complaints. A complaints folder has been maintained. There has been one complaint received to date for 2015. The complaint has been managed appropriately. The complaints register is up to date.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>The family member (from the hospital) interviewed stated they are informed of changes in health status and incidents/accidents. This was confirmed on the eight incident forms sampled. Families receive information and explanation on the services provided at Kerridge House. Five residents (three rest home and two hospital) and one family member (hospital) state the care lead has an open door policy and is available at any time should they have concerns. Resident meetings are held monthly. Residents and family are advised in writing of their eligibility and</p>

		<p>the process to become a subsidised resident should they wish to do so. The service has standard operating procedures available for access to interpreter services for residents (and their family/whānau). If residents or family/whanau have difficulty with written or spoken English the interpreter services are made available.</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>	CI	<p>Kerridge House is owned and operated by the Selwyn Foundation and is one of four current services operating from the village site. The service provides care for up to 59 residents requiring rest home or hospital level care. On the day of the audit, there were 46 rest home residents and 11 hospital level residents.</p> <p>The aged care facilities on the site, including Kerridge House are overseen by the assistant village manager who has a business studies BA degree and a post graduate Diploma in Housing. She has previously managed another Selwyn site for three years. She is supported at Kerridge House by a care lead (CL) that is a registered nurse and was appointed to the role eight weeks ago. He has 10 years' experience in aged care in Australia with the last three years in aged care management. The CL has completed orientation including relevant competencies. The Selwyn Care foundation has an overarching five year strategic business plan. Kerridge House has a 2015 specific quality plan including a number of actions with timeframes. The Kerridge House 2014 plan has been reviewed. The service has continued to exceed in this standard.</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>	CI	<p>The quality plan describes the Kerridge House quality improvement processes. The organisation wide risk management plan describes objectives, management controls and assigned responsibility. Progress with the quality and risk management programme has been monitored through the staff meeting and input from the organisations quality manager. All quality data is electronically logged and monitored by the care lead, the quality manager and the assistant village manager. Meeting minutes have been maintained and staff are expected to read the minutes. Minutes sighted have included actions to achieve compliance where relevant. Discussions with staff confirmed their involvement in the quality programme. Data is collected on complaints, accidents, incidents, infection control and restraint use. The internal audit schedule for 2014 has been completed and for 2015 is underway. Audits are delegated out to relevant personnel to complete. The organisations clinical nurse specialist (CNS) completes clinical compliance audits. Areas of non-compliance identified at audits have been actioned for improvement. Specific quality</p>

		<p>improvements have been identified and benchmarking with other facilities occurs on data collected. The service has implemented a health and safety management system. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. All of Selwyn care health and safety representatives meet for a six monthly forum which includes training and updates. The service has comprehensive standard operating procedures to support service delivery. Policies and procedures align with the client care plans. A document control policy outlines the system implemented whereby all policies and procedures are reviewed regularly. Falls prevention strategies are implemented for individual residents. Relatives and resident surveyed was last conducted November 2013. Results were collated by an external agency with an overall analysis for each survey category with ranking within the company. The 2014 survey was delayed due to the village re-structure however has been re-scheduled for 2015.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Incident and accident data has been collected and analysed. Discussions with the service confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Eight resident related incident reports for March 2015 were reviewed. All reports and corresponding resident files reviewed evidence that appropriate clinical care has been provided following an incident. Neurological observations had been completed following head injuries. The service benchmarks incident data with other facilities in the Selwyn Foundation group. All incidents are electronically logged and quality improvement plans are raised when required. A critical incident process has been introduced within Selwyn Foundation. Selwyn Kerridge House has reported one critical incident.</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>The recruitment and staff selection process requires that relevant checks have been completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates is kept. Five staff files were reviewed and included all appropriate documentation. Staff turnover was reported as low, with a number of long serving staff. The service has a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Annual appraisals are conducted for all staff. A completed in-service calendar for 2014 exceeded eight hours annually and</p>

		the 2015 in-service programme is being completed. Training is delivered in four one day modules per year that covers compulsory education requirements. The care lead is provided with ongoing training relevant to the role within the wider group.
<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>	FA	Kerridge House has a fortnightly roster in place which provides sufficient staffing cover for the provision of care for rest home and up to 15 hospital level residents. The care lead (a registered nurse) works full time Monday to Friday and is supported by a registered nursing team 24/7. Caregivers and family interviewed advised that sufficient staff are on the roster for each shift. Selwyn Foundation has its own bureau of nursing staff to cover sick leave, annual leave etc.
<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>	PA Low	All medication is managed appropriately in line with required guidelines and legislation. The RN's and senior HCAs responsible for the administering of medication complete annual medication competencies and attend annual medication education. The RN checks all medications on delivery against the medication chart. All medication sighted were within the expiry dates. There were two self-medicating residents who had self-medication competencies completed as were monitored as per self-medication policy. The standing orders are current. Ten medication charts were sampled. There is an improvement required around discontinued medications. The GP had reviewed the medication charts at least three monthly.
<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>	FA	<p>An external contractor provides all meals from an on-site main kitchen. Meals are delivered in hot boxes and served from the bain marie in the facility kitchenette. All meals are served by contracted kitchen hands. The resident likes and dislikes are known and these and special diets catered to. Alternative choices are offered for dislikes. The head cook (interviewed) visits the facility at least weekly and monitors the service including meeting with residents and receiving feedback on the meals. The menu has had dietitian input. The dietitian is involved for any residents with weight loss. The external contractor is responsible for ensuring compliance with food safety standards.</p> <p>D19.2k Kitchen staff have completed food handling training and chemical safety.</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>FA</p>	<p>When a resident's condition alters, the registered nurse initiates a review and if required GP or specialist consultation. Relatives confirmed in interview that they are kept informed on any changes to resident conditions.</p> <p>HCA's and the RN interviewed stated that they have all the equipment and resources required to deliver safe care. Family/whanau interviewed confirmed their relative's needs are being met.</p> <p>D18.3 and 4: Dressing supplies are available. There were three minor wounds in the rest home and two minor lesions in the hospital. One resident in the hospital wing has an early pressure area. Wound assessment and wound management plans were in place for all wounds. A short term care plan has been completed and includes dietary supplementary. Specialist continence and wound care advice is available as needed and this could be described by the registered nurse and care lead.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>CI</p>	<p>The service employs an activity coordinator Sunday to Friday and the Selwyn Village qualified diversional therapist (DT) is on site Friday and Saturday. The DT oversees the seven day week programme. Group and individual activities are focused on the individual abilities and preferences. Residents are involved in household activities and meaningful activities. Theme days and events are celebrated. There are twice weekly outings. Spiritual needs are met with on-site church services.</p> <p>Family input is sought to complete a resident profile and lifestyle questionnaire. Activity plans are reviewed at the same time as the care plans. Resources are readily available. The service continues to exceed requirements for this standard.</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>Evaluation timeframes are specified in policies and procedures. Initial care plans sighted were evaluated by the RN within three weeks.</p> <p>D16.4a Care plans are evaluated by the registered nurse at least six monthly or when changes to care occurs for residents. Staff document progress in each resident's clinical record daily and as changes occurs. A three monthly review by the medical practitioner occurs for all medically stable residents or more frequently if a resident's health is more complex. Short term care plans sighted for short term needs had been reviewed regularly. Family/whanau are invited to provide input into</p>

		the care plan review.
<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>	FA	There is a current building warrant of fitness which expires on 28 May 2015.
<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>	FA	The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections and definition of infections. The infection control coordinator (care lead/RN) uses the information obtained through surveillance to plan and determine infection control activities, resources, and education needs within the facility. An infection report form and short term care plan is completed for the management of a suspected/diagnosed infection. All infections are individually logged on the electronic database. Trends (monthly and yearly comparisons) and quality improvements are identified and monitored. Corrective actions are developed when needed and implemented. Antibiotic use is monitored by the IC coordinator and GP. Staff interviewed confirmed they are kept informed on any infection control matters, trends, corrective actions and quality initiatives relating to infection control activities.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	There is a restraint policy (reviewed August 2014) that included comprehensive restraint procedures and aligns with the standards. The care lead is the restraint coordinator. There are no enablers in use. The service has two residents with approved restraints. Staff receive training in restraint and enablers on orientation and is ongoing. All Selwyn restraint coordinators meet six monthly which includes training.

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	Prescribing requirements for regular and as required medications met legislative requirements for ten out of ten medication charts sampled.	Discontinued medications did not evidence a stop date and GP signature on six out of ten medication charts sampled.	<p>Ensure discontinued medications are dated and signed by the GP.</p> <p>30 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, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.2.1.1</p> <p>The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.</p>	CI	<p>Kerridge House is owned and operated by the Selwyn Foundation and is one of four current services operating from the village site. The service provides care for up to 59 residents requiring rest home or hospital level care. On the day of the audit, there were 46 rest home residents and 11 hospital level residents.</p> <p>The organisation undertook a restructure in 2014.</p>	<p>The service continues to exceed the standard around business goals and direction. The organisation has a strategic plan 2013-2017 that contains seven goals a) charitable mission b) continuum of care c) centre of excellence d) partnership (with key organisations e) brand f) environmental sustainability and g) financial strength. The strategic plan is reviewed regularly. Kerridge House had a 2014 business plan documented goals. The goals were formally reviewed six monthly (in June and December 2014) between the care lead and the assistant village manager. Goals achieved in 2014 included (but were not limited to): a) continuing to foster Selwyn’s at home way with Kerridge’s unique culture and b) rebuild customer confidence that Kerridge can provide the service in: (i) involvement, choices and cultural and spiritual needs being met in care</p>

			<p>planning, (ii) reduction in laundry lost property and timely delivery of clothes (there have been no complaints in this area) and (iii) the content of response and time to address complaints has been addressed (there have been no complaints).</p> <p>Examples of goals for 2015 include: a) streamlining all systems and process across all sites in the village enabling care leads to provide cover for each other; b) Kerridge House is the first to trial the "clown doctors", a N.Z. charitable trust whose mission is to bring joy and laughter to children and support older people's health. The trial begins on 18 May 2015 for three hours a fortnight, c) encourage and recruit volunteers for innovative projects and d) provide an activity programme over seven 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>	CI	<p>The service continues to exceed the standard around the quality and risk management system. The process around internal auditing and the raising of 'quality improvement plans' (QIP's); continues to be developed and improved. Senior staff attended further training in March 2012 around internal auditing to ensure all staff understood the correct process. When the restructuring occurred and new 'care leads (managers) were appointed for services the two day orientation for new care leads and assistant care leads in August 2014 included the internal auditing process and the raising of QIP's. QIP's continue to be managed through the organisational quality system. The number of QIP's raised by Kerridge increased to 33 in 2014. This is increased due to the frequency of some of the audits being increased, providing more opportunities to identify shortfalls. The care lead interviewed is very familiar with the quality and risk</p>	<p>The service continues to exceed the standard around the quality and risk management system. The process around internal auditing and the raising of 'quality improvement plans' (QIP's); continues to be developed and improved. Senior staff attended further training in March 2012 around internal auditing to ensure all staff understood the correct process. When the restructuring occurred and new 'care leads (managers) were appointed for services the two day orientation for new care leads and assistant care leads in August 2014 included the internal auditing process and the raising of QIP's. QIP's continue to be managed through the organisational quality system. The number of QIP's raised by Kerridge increased to 33 in 2014. This is increased due to the frequency of some of the audits being increased, providing more opportunities to identify shortfalls. The care lead interviewed is very familiar with the quality and risk</p>

		management process.	management process.
<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>	CI	<p>There are a number of on-going quality improvements identified through meeting minutes and as a result of analysis of quality data collected. Kerridge House is proactive in developing and implementing quality initiatives.</p>	<p>There are a number of on-going quality improvements identified through meeting minutes and as a result of analysis of quality data collected. Kerridge House is proactive in developing and implementing quality initiatives. Staff interviewed confirmed quality improvements and quality initiatives are discussed at staff meetings. An example is the QIP raised in April 2014 when the rate of complaints at Kerridge had been above the organisation KPI for two months. This resulted in an analysis of all received complaints and a number of improvements to attempt to reduce complaint numbers including the introduction of a laundry bundle system, and the administrator working on the comfort care accounts. Some complaints were addressed by the kitchen facilities being completed and moving back to the Selwyn Village site. The number of complaints has decreased in May 2015 following this QIP. A critical incident process has been introduced within Selwyn Foundation. The service has reported one critical incident. The care lead described the process and debriefing session as an opportunity for learning.</p>
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	CI	<p>The activity programme focuses on individual social and recreational preferences in line with the Eden way. The activity coordinator is an Eden Associate.</p>	<p>The service continues to exceed the standard around activities. All residents receive a copy of the weekly programme. The activity coordinator and DT make contact each day with residents. Residents choose activities they wish to participate in. One on one time is spent with residents who are unable or choose not to participate in group activities. Residents are involved in daily household chores as they choose such as baking</p>

			<p>and gardening. The programme is flexible and encourages resident choice of activities. Many cultural needs are met with families being involved in cultural days. The men's group (combined with another Selwyn group) meet monthly with a guest speaker and visits to places of interest. Community links are maintained with many community visitors such as the animal visits, blind society, school children, girl guides and entertainers. Twenty volunteers are involved in Kerridge House under the guidance of a Volunteer manager. A recent example is volunteers who have travelled visited the home and talk about their travels (as observed on the day of audit).</p>
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End of the report.