

Selwyn Care Limited - Selwyn Heights

Introduction

This report records the results of a Certification 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: 4 April 2016 End date: 5 April 2016
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:	66

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 owned and operated by the Selwyn Foundation and cares for up to 96 residents requiring rest home or hospital level care. On the day of the audit there were 66 residents. Twelve hospital rooms were closed for refurbishment at the time of the audit. All residents were under the Age Related Care Contract. The hospital and rest home buildings are adjoining.

The service is managed by a village manager, who has both management and aged care experience. The care centre is over seen by the care lead, who is a registered nurse with experience in aged care. She is supported by an assistant village manager, a senior registered nurse and the group residential care manager. Residents, relatives and the GP interviewed spoke positively about the service provided.

This certification audit was conducted against the relevant Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of resident's and staff files, observations and interviews with residents, relatives, staff and management.

The service has exceeded the standard around weight management, infection control and activities.

This audit has identified areas for improvement around the preventative maintenance programme.

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.		All standards applicable to this service fully attained with some standards exceeded.
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Policies and procedures adhere with the requirements of the Code of Health and Disability Services Consumers' Rights (the Code). Residents and families are informed regarding the Code and staff receives ongoing training about the Code.

The personal privacy and values of residents are respected. There is an established Māori health plan in place. Individual care plans reference the cultural needs of residents. Discussions with residents and relatives confirmed that residents and where appropriate their families are involved in care decisions. Regular contact is maintained with families including if a resident is involved in an incident or has a change in their current health. Families and friends are able to visit residents at times that meet their needs. Examples of good practice were provided.

There is an established system for the management of complaints, which meets guidelines established by the Health and Disability Commissioner.

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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Services are planned, coordinated, and are appropriate to the needs of the residents. An assistant village manager and care lead are responsible for the day-to-day operations. Goals are documented for the service with evidence of regular reviews. A quality

and risk management programme is embedded. Data is collected, analysed, discussed and changes made as a result of trend analysis. Corrective actions are implemented and evaluated where opportunities for improvements are identified.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. Ongoing education and training is in place, which includes in-service education and competency assessments.

Registered nursing cover is provided 24 hours a day, 7 days a week. Residents and families report that staffing levels are adequate to meet the needs of the residents.

The integrated residents' files are appropriate to the service type.

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.		Standards applicable to this service fully attained.
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Residents are assessed prior to entry to the service. A baseline assessment is completed upon admission and an interRAI assessment within three weeks. Lifestyle support plans are developed by the service's registered nurses, who also have the responsibility for maintaining and reviewing the support plans.

InterRAI assessment tools and monitoring forms are used to assess the level of risk and ongoing support required for residents. Lifestyle support plans are evaluated six monthly or more frequently when clinically indicated. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files.

The activity programme is varied and reflects the interests of the residents including community interactions.

There are medication management policies that are comprehensive and direct staff in terms of their responsibilities in each stage of medication management. Competencies are completed. Medication profiles are up to date and reviewed by the general practitioner three monthly or earlier if necessary.

The menu is designed and reviewed by a registered dietitian. Residents' individual needs are identified. There is a process in place to ensure changes to residents' dietary needs are communicated to the kitchen. Regular audits of the kitchen occur.

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.		Some standards applicable to this service partially attained and of low risk.
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The service displays a current building warrant of fitness for each of the two buildings. Reactive maintenance is carried out. Furniture and fittings are selected with consideration to residents' abilities and functioning. Residents can and do bring in their own furnishings for their rooms. The service has policies and procedures for management of waste and hazardous substances and incidents are reported on in a timely manner. Staff receives training and education to ensure safe and appropriate handling of waste and hazardous substances. Documented policies and procedures for the cleaning services are implemented with monitoring systems in place to evaluate the effectiveness of these services. Laundry is completed off-site. Policies and procedures are in place for essential, emergency and security services, with adequate supplies should a disaster occur. There is staff on duty with a current first aid certificate.

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.

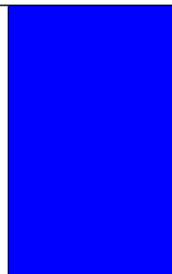


Standards applicable to this service fully attained.

Staff regularly receives training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. A register is maintained by the restraint coordinator. Ten residents were using restraints and no residents were 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.



All standards applicable to this service fully attained with some standards exceeded.

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and also as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner. There have been no outbreaks since the previous audit.

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	2	47	0	1	0	0	0
Criteria	5	95	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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Selwyn Heights policies and procedures are being implemented that align with the requirements of the Code of Health and Disability Services Consumers' Rights (the Code). Families and residents are provided with information on admission which includes information about the Code. Staff receives training about resident rights at orientation and as part of the annual in-service programme. Interviews with care staff (seven caregivers - one who works across the rest home and hospital, two from the rest home and four from the hospital), four registered nurses (one from the rest home and three from the hospital), one activities coordinator and two activities assistants) confirmed their understanding of the Code. Ten residents (seven rest home level, three hospital level) and six relatives (five hospital level, one rest home level) interviewed confirmed that staff respect privacy and support residents in making choices.</p>
<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</p>	FA	<p>The service has policies and procedures relating to informed consent and advanced directives. All nine resident files reviewed included signed informed consent forms and advanced directive instructions. Staff are aware of advanced directives. Admission agreements were sighted which were signed by the resident or nominated representative. Discussion with residents and families identified that the service actively involves them in decision making.</p>

give informed consent.		
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	Residents interviewed confirmed they are aware of their right to access independent advocacy services. Discussions with relatives confirmed the service provided opportunities for the family/EPOA to be involved in decisions. The chaplain is identified by staff and residents as an advocate. The resident files include information on resident's family/whānau and chosen social networks.
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. The activities programme includes opportunities to attend events outside of the facility. Residents are supported and encouraged to remain involved in the community. Relatives and friends are encouraged to be involved with the service and care.
<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>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission. Interviews with all residents and relatives confirmed their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints.</p> <p>There is a complaints register that includes written and verbal complaints, dates and actions taken. Complaints are being managed in a timely manner meeting requirements determined by the Health and Disability Commissioner (HDC). There is evidence of lodged complaints being discussed in management and staff meetings. All complaints received have been documented as resolved with appropriate corrective actions implemented. This includes one unsubstantiated complaint lodged with the district health board.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	There is an information pack given to prospective residents and families that includes information about the Code and the nationwide advocacy service. There is the opportunity to discuss aspects of the Code during the admission process. Residents and relatives interviewed confirmed that information had been provided to them around the Code. Large print posters of the Code and advocacy information are displayed throughout the facility. A manager discusses the information pack with residents/relatives on admission. Families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.

<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>A tour of the premises confirmed there were areas that support personal privacy for residents. Staff were observed to be respectful of residents' privacy by knocking on doors prior to entering resident rooms. Staff could describe definitions around abuse and neglect that aligned with policy. Residents and relatives interviewed confirmed that staff treats residents with respect.</p> <p>The service philosophy promotes quality of life and involves residents in decisions about their care. Resident preferences are identified during the admission and care planning process and include family involvement. Interviews with residents confirmed their values and beliefs were considered. Caregivers could describe how choice is incorporated into resident cares.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The Māori health plan policy for the organisation references local Māori healthcare providers regionally within New Zealand and provides recognition of Māori values and beliefs. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with disability and other community representative groups as requested by the resident/family. Cultural needs are addressed in the care plan. Residents who identified as Māori confirmed their cultural needs were being met by the service.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>An initial care planning meeting is carried out where the resident and/or whānau as appropriate are invited to be involved. Individual beliefs or values are discussed and incorporated into the care plan. Six monthly multidisciplinary team meetings occur to assess if needs are being met. Family are invited to attend. Discussions with relatives confirmed that residents' values and beliefs are considered. Residents interviewed confirmed that staff take into account their values and beliefs.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Staff job descriptions include responsibilities. The monthly staff meetings include discussions around professional boundaries and concerns as they arise. Management provided guidelines and examples of mentoring for specific situations. Interviews with the managers and care staff confirmed their awareness of professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p>	FA	<p>Policies and procedures are aligned with current accepted best practice. The content of policy and</p>

<p>Consumers receive services of an appropriate standard.</p>		<p>procedures are sufficiently detailed to allow effective implementation by staff.</p> <p>An annual in-service training programme is implemented as per the training plan. Registered nurses are able to attend DHB training and caregivers are provided with a training programme. The service benchmarks with other Selwyn Foundation services and uses outcomes to improve resident outcomes. Feedback is provided to staff via the staff/quality meetings.</p> <p>There is a minimum of one registered nurse on each shift. Residents and family advised that caregivers are caring and competent. A number of process improvements have been implemented resulting in improvements to resident wellbeing (link to CI 1.3.13.1, 1.3.7.1 and 3.5.7).</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>CI</p>	<p>There is an accident/incident reporting policy to guide staff in their responsibility around open disclosure. Staff are required to record family notification when entering an incident into the system. The sample of adverse events reviewed met this requirement. Family members interviewed confirmed they are notified following a change of health status of their family member. The service has exceeded the standard around ensuring that all staff are able to communicate effectively with residents.</p> <p>There is an interpreter policy in place and contact details of interpreters were 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>	<p>FA</p>	<p>Selwyn Heights is a Selwyn Foundation aged care facility located in Auckland. The facility is certified to provide rest home and hospital (geriatric and medical) level care for up to 96 residents. Twelve hospital level beds were closed for refurbishment during the audit. Thirty-six beds are dedicated to rest home level of care and sixty to hospital level care.</p> <p>There were 66 residents at the time of audit - 24 rest home level and 42 hospital level. There were no residents on the medical component and all residents were on the Aged Related Care contract.</p> <p>The organisational strategic plan 2013 to 2017 documents organisational goals. These are reflected in the 2016 Selwyn Heights business plan which describes the vision, values and objectives of Selwyn Heights. Annual goals are linked to the business plan and reflect regular reviews via facility meetings.</p> <p>The village manager has aged care management and hospitality management experience. The care home is primarily overseen by the care lead. The care lead is a registered nurse with aged care experience, who has been in the role for three years. The village manager and care lead are supported by an assistant village manager, a senior registered nurse and the group residential care manager.</p>

		The village manager and care lead have maintained at least eight hours of professional development activities related to managing an aged care facility.
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	The assistant village manager and senior registered nurse covers during the temporary absence of the care lead.
<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>	FA	<p>An established quality and risk management system is embedded into practice. Quality and risk performance is reported across facility meetings and to the group residential care manager. Discussions with the managers (group residential care manager, village manager, assistant village manager, care lead and senior registered nurse), the GP, and staff reflected staff involvement in quality and risk management processes.</p> <p>Resident meetings are monthly. Minutes are maintained. Annual resident and relative surveys are completed with results communicated to residents and staff. Survey results reflect high levels of satisfaction.</p> <p>The service has policies and procedures 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. The service's policies are reviewed at a national level by the clinical governance group with input from facility staff every two years. Clinical guidelines are in place to assist care staff. Updates to policies included procedures around the implementation of interRAI.</p> <p>The quality monitoring programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation. There are clear guidelines and templates for reporting. The facility has implemented established processes to collect, analyse and evaluate data. This is utilised for service improvements. Key performance areas are benchmarked against other Selwyn facilities. Quality improvement plans (QIP's) are developed when service shortfalls are identified and these are monitored by group office. Results are communicated to staff at staff/quality meetings and reflect actions being implemented and signed off when completed.</p> <p>Health and safety policies are implemented and monitored by the health and safety committee.</p>

		<p>Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made.</p> <p>Falls prevention strategies are in place including (but not limited to): sensor mats, increased monitoring, identification and meeting of individual needs and mattress perimeter guards.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>There is an incident/accident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise and debriefing. Individual incident/accident reports are completed for each incident/accident with immediate action noted and any follow-up action required.</p> <p>A review of ten incident/accident forms (a sample from February and March 2016) identified that forms are fully completed and include follow up by a registered nurse. Neurological observations are completed for any suspected injury to the head. The senior registered nurse and care lead are involved in the adverse event process.</p> <p>The group residential care manager was able to identify situations that would be reported to statutory authorities including (but not limited to) infectious diseases, serious accidents and unexpected death. One section 31 notification was being made at the time of the audit regarding an evacuation and fire department callout. This was as a result of an electrical fault that did not result in a fire.</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>Human resources policies include recruitment, selection, orientation and staff training and development. Seven staff files reviewed (the senior registered nurse, one other registered nurse, a cleaner, the cook, the activities coordinator and two caregivers) included a comprehensive recruitment process which included reference checking, signed employment contracts and job descriptions, completed orientation programmes and annual performance appraisals.</p> <p>Registered nursing staff and other health practitioner practising certificates are maintained on file.</p> <p>The orientation programme provides new staff with relevant information for safe work practice. There is an implemented annual education and training plan that exceeds eight hours annually. The training plan is implemented using a train the trainer model where key staff are trained to provide education sessions on subjects that cover a number of required trainings. Aspects of training are provided during full day training sessions. The service has exceeded the required standard around staff training. Incidental training is provided according to identified need and at</p>

		<p>staff request. There is an attendance register for each training session and an individual staff member record of training.</p> <p>Registered nurses are supported to maintain their professional competency. Five of the seven permanent registered nurses have completed their interRAI training. There are implemented competencies for registered nurses.</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>	FA	<p>A policy is in place for determining staffing levels and skills mix for safe service delivery. Rosters implement the staffing rationale. In the hospital there are three registered nurses (over two floors) on morning shift, two on afternoon shift and one on night shift. A registered nurse works morning shift five days per week in the rest home and out of these hours, the hospital registered nurse covers urgent issues. A registered nurse from the management team is on call at all times. Activities are provided five days a week.</p> <p>Staff were visible and were attending to call bells in a timely manner as confirmed by all residents interviewed. Staff interviewed stated that overall the staffing levels are satisfactory and that the managers provide good support. Residents and family members interviewed report there are sufficient staff numbers.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident files were appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access. Entries are legible, dated and signed by the relevant caregiver or nurse including designation. Individual resident files demonstrate service integration.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>All residents are assessed prior to entry for rest home or hospital level of care. The service has specific information available for residents/families/whānau at entry and includes associated information such as the Code of Rights, advocacy and the complaints procedure.</p> <p>A comprehensive admission booklet is available to all residents/family/whānau on enquiry or admission. The information includes examples of how services can be accessed that are not included in the agreement. Registered nurses interviewed were able to describe the entry and admission process. The GP is notified of a new admission.</p> <p>Eight signed admission agreements were sighted. The admission agreement reviewed aligns with</p>

		a) – k) of the ARC contract. Exclusions from the service are included in the admission agreement.
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>The service has transfer/discharge/exit policy and procedures in place. The procedures include a transfer/discharge form and ‘the yellow envelope’ is used. The RNs report that they include copies of all the required information in the envelope.</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>	FA	<p>Medicine management policies and procedures are in place and implemented. They follow recognised standards and guidelines for safe medicine management practice. There were four medication storage areas. All areas and fridge temperatures met requirements. Unwanted or expired medications are collected by the pharmacy weekly. Medicines (robotic rolls) are delivered weekly by the pharmacy and checked by an RN on-site. An RN does a weekly check for expired medication. All eye drops were noted to be dated at opening. No expired medications were noted on any trolleys or medication storage shelves. A bulk supply of minimal stock medicines was available in the hospital.</p> <p>A medication round was observed; the procedure followed by the registered nurse was correct and safe. The service uses a paper based medication administration system.</p> <p>Registered nurses administer medications to hospital residents. Carers complete competency for checking only. Carers in the rest home have full medicine competency and administer medicines on pm and night duties.</p> <p>The self-medicating policy includes procedures on the safe administration of medicines. Two residents self-medicating have three monthly competency reviews completed.</p> <p>Eighteen individual resident’s medication charts were sighted. Resident medication charts are identified with photographs and allergies are recorded. All charts had been correctly signed and all discontinued medications had been signed and dated. All PRN medications included indication for use. There was evidence of three monthly GP review. Pain monitoring charts were attached to seven of the medication charts.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer’s individual food, fluids</p>	FA	<p>The residents’ individual food, fluids and nutritional needs were met. Residents are provided with a balanced diet which meets their cultural and nutritional requirements. The food service is contracted to an external provider. The meals are cooked on-site. The kitchen also provides meals to the adjoining village. Food is sent to the individual unit servery’s in bain maries. Fridge</p>

<p>and nutritional needs are met where this service is a component of service delivery.</p>		<p>temperatures are recorded for the fridge in each servery.</p> <p>The external contractor has a summer and winter menu reviewed by a registered dietitian as per the contract and they also provide dietetic input into the provision of special menus and diets where required. A dietary assessment is completed on all residents at the time they are admitted. Residents with weight loss are reviewed and are placed, if appropriate, on the REAP programme – Replenish Energy and Protein food fortification. Residents with special dietary needs have these needs identified. Resource information on these diets is available in the kitchen and via the dietitian.</p> <p>Special equipment is available and on observing mealtimes, it was noted there were sufficient staff to assist residents.</p> <p>A kitchen cleaning schedule was in place and implemented. Labels and dates on all containers and records of food temperature monitoring were maintained. The chiller, fridge and freezer temperatures were monitored. The kitchen was observed to be clean and well organised. All aspects of food procurement, production, preparation, storage, delivery and disposal complied with current legislation and guidelines.</p> <p>The service has exceeded the required standard around the management of residents with weight loss.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>The reason for declining service entry to residents to the service is recorded. Should this occur, the service stated it would be communicated to the resident/family/whānau and the appropriate referrer. Potential residents would only be declined if there were no beds available or they did not meet the service requirements.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>The resident's needs, support requirements and preferences were collected and recorded within required timeframes. The RNs complete a variety of assessment tools on admission along with the interRAI assessment tool. Assessments reviewed included falls, pressure risk, dietary needs, continence, pain, mobility, cognitive and depression. All resident files sampled had an interRAI assessment. The outcomes of these assessments were reflected in all long-term care plans reviewed.</p> <p>Pain assessments were evidenced as completed with ongoing monitoring recorded, for residents requiring administration of controlled medication as part of prescribed pain management plan.</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 long-term care plans reviewed were resident focused, integrated and promoted continuity of service delivery. An initial plan of care was developed on admission while the long-term plans were developed within three weeks of admission. The facility uses an integrated document system where the GP, nurse practitioner, allied services, the RNs, activities coordinators, physiotherapist and other visiting health providers write their care notes.</p> <p>The resident files had sections for the resident's profile, details, observations, long-term care plans, monitoring and risk assessments. Interventions sighted were consistent with the assessed needs and best practice. Goals were realistic, achievable and clearly documented. The service recorded interventions for the achievement of the goals.</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>Residents received adequate and appropriate services meeting their assessed needs and desired outcomes. Interventions were documented for each goal in the long-term care plans. Interventions from allied health providers were included in the long-term and short-term care plans.</p> <p>Dressing supplies and continence products are readily available. Registered nurses interviewed were able to describe access to specialist services if required.</p> <p>Wound assessment and wound management plans were in place for eight residents with wounds; four skin tears, three chronic ulcers and a grade II pressure injury. The pressure injury is improving. All wounds have documented assessments and a treatment plan in place. All wounds show evidence of healing with the exception of the chronic ulcers.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activity programme confirmed that independence was encouraged and choices were offered to residents. The activity coordinator and two assistants coordinated the programme. A wide range of activities, addressing the abilities and needs of residents in the hospital and rest home, were offered.</p> <p>Activities included physical, mental, spiritual and social aspects of life to improve and maintain residents' wellbeing.</p> <p>On admission, an activity coordinator completes an assessment for each resident and an activity plan is completed. A record is kept of individual resident's activities and progress notes are completed monthly. Reviews are conducted six monthly (or earlier should the residents condition determine) as part of the care plan evaluation/review.</p>

		<p>Residents and family interviews confirmed they enjoyed the variety of activities and were satisfied with the activities programme. Activities included outings as well as community involvement. A library bus calls and the service owns a van. The three activities coordinators have current first aid certificates. There are volunteers that assist with a variety of activities including van outings.</p> <p>A forum is held monthly where residents and relatives have input. Minutes are recorded at the forum, quality improvements identified and feedback given.</p> <p>The service has exceeded the standard around activities provided.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Long-term care plans have been reviewed six monthly and updated when needs changed. Clinical reviews were documented in the multidisciplinary review (MDR) records, which included input from the GP, RNs, activities coordinator, physio and resident/family. Progress notes were completed and reflected response to interventions and treatments. Changes to care were documented. Documentation of GP visits were evidence that reviews were occurring at least three monthly. Short-term care plans were in use for short term issues.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>The service facilitates access to other services (medical and non-medical) and where access occurs, referral documentation is maintained. Residents' and/ or their family/whānau are involved as appropriate when referral to another service occurs. Registered nurses interviewed described the referral process should they require assistance.</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>	FA	<p>The service has documented policies and procedures for the safe and appropriate storage and disposal of waste and hazardous substances. Waste is appropriately managed.</p> <p>Chemicals were secured in designated locked cupboards. Chemicals were labelled and safety data sheets were available throughout the facility and accessible to staff. Safe chemical handling training has been provided. Personal protective equipment/clothing was sighted in all high risk areas. Staff were observed wearing protective equipment and demonstrated knowledge of handling chemicals.</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>PA Low</p>	<p>The service displays a current building warrant of fitness for each of the two buildings. There is a maintenance work notification book for staff to communicate with maintenance staff about issues and areas that requires attention. Hot water temperatures are monitored and recorded monthly. The building is currently undergoing refurbishment and the completed sections are well maintained. However, preventative maintenance has not occurred in a consistently planned manner. The maintenance person is available on call after-hours. Electrical equipment is tested and tagged. All hoists have been checked and serviced and medical equipment has been calibrated and checked. The facility van is registered and has a current warrant of fitness.</p> <p>There are outside courtyard areas with seating, tables and shaded areas that are easily accessible. Work is continuing on some of the areas. Pathways, seating and grounds appear well maintained. All hazards have been identified in the hazard register.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>There are sufficient communal showers and toilets for residents. Some resident rooms have a full ensuite and some have a toilet and basin. Resident rooms have hand-washing facilities with soap dispensers and paper towels. Communal bathroom and toilet facilities have privacy curtains and locks.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>Residents rooms are of an adequate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Transfer of residents can occur between rooms. Mobility aids can be managed in communal bathrooms.</p> <p>Rooms can be personalised with furnishings, photos and other personal adornments and the service encouraged residents to make the room their own.</p> <p>There was room to store mobility aids such as walking frames in the bedroom safely during the day and night if required.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And</p>	<p>FA</p>	<p>There are communal lounge/dining areas and a large activities lounge along with an art room and chapel. There are smaller seating areas for residents and families around the facility. Furniture in all areas is arranged to allow residents to freely mobilise. Activities can occur in many areas</p>

<p>Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>		<p>including the courtyards.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>All laundry is completed off-site with the exception of rest home personal laundry. Residents and relatives expressed satisfaction with cleaning and laundry services. The service has secure cupboards for the storage of cleaning chemicals. Chemicals are labelled. Material safety data sheets are displayed. Cleaning processes are monitored for effectiveness and compliance with the service policies and procedures. Cleaning staff have completed chemical safety training.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>There is at least one staff member on duty at all times with a first aid certificate. All registered nurses have current first aid certificates. Emergency preparedness plans are accessible to staff and includes management of all potential emergency situations. The service has implemented policies and procedures for civil defence and other emergencies. The service has civil defence resources and supplies. There are sufficient first aid and dressing supplies available. The service has an approved fire evacuation scheme. Fire evacuation training and drills are conducted six monthly.</p> <p>There are alternative cooking facilities and two large tanks storing emergency water. Call bells were situated in all communal areas, toilets, bathrooms and personal bedrooms. Residents were sighted to have call bells within reach during the audit. The service has a visitor's book at reception for all visitors including contractors to sign in and out. Access by the public is limited to the main entrance of each building. Appropriate security systems are in place.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>Residents are provided with adequate natural light, safe ventilation and an environment that is maintained at a safe and comfortable temperature.</p>

<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>Selwyn Heights has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system and the Selwyn KPI's. The senior registered nurse is the designated infection control nurse with support from the care lead. The quality meeting team is the infection control team. Minutes are available for staff. Audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The Selwyn Foundation infection control programme was last reviewed in September 2015.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The senior registered nurse at Selwyn Heights is the designated infection control (IC) nurse. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse and IC team (comprising all staff) has good external support from the local laboratory infection control team and IC nurse specialist at the DHB. The infection control team is representative of the facility. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>There are Selwyn Foundation infection control policies and procedures appropriate for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies were developed by the Selwyn clinical governance and have been reviewed and updated.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and</p>	FA	<p>The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education has occurred for staff. The infection control nurse has completed infection control training through the Selwyn infection control coordinators bi-annual meeting/training days. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is</p>

consumers.		appropriate to their needs and this is documented in medical records.
<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>	CI	<p>Infection surveillance is an integral part of the infection control programme and is described in Selwyn's infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. Short-term care plans are used. Surveillance of all infections is entered on to a monthly infection summary. This data is monitored and evaluated monthly and annually and provided to Selwyn head office for benchmarking. Infections are part of the key performance indicators. Outcomes and actions are discussed at quality/staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible. There have been no outbreaks since the previous audit.</p> <p>The service has exceeded the standard around the use of surveillance activities to improve outcomes for residents.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Restraint practices are only used where it is clinically indicated and other de-escalation strategies have been ineffective. Restraint minimisation policies and procedures are comprehensive and include definitions, processes and use of restraints and enablers.</p> <p>There were no residents using enablers and ten hospital residents with restraints (seven bedrails and three lap belts).</p> <p>Staff training is in place around restraint minimisation and enablers, falls prevention and management of challenging behaviours.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service</p>	FA	<p>The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities of the restraint coordinator (a registered nurse) and for staff are documented and understood. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements.</p>

providers and others.		
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>A restraint assessment tool is completed for residents requiring an approved restraint for safety. Assessments are undertaken by the restraint coordinator in partnership with the RNs, GP, resident and their family/whānau. Restraint assessments are based on information in the care plan, resident/family discussions and observations.</p> <p>Ongoing consultation with the resident and family/whānau are evident. Three hospital level residents' files where restraint was in use (lap belt and bed rails) was selected for review. The completed assessment considered those listed in 2.2.2.1 (a) - (h).</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint.</p> <p>The use of restraint is linked to the residents' care plans. Internal restraint audits measure staff compliance in following restraint procedures. Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Monitoring is documented on a specific restraint monitoring form, evidenced in three resident files where restraint was being used.</p> <p>A restraint register is in place providing an auditable record of restraint use and is completed for all residents requiring restraints and enablers.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations are conducted monthly and restraint use is discussed monthly at both registered nurse and staff/quality meetings. A review of three resident files identified that evaluations are up to date.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>The restraint minimisation programme is discussed and reviewed at the six monthly organisation-wide restraint coordinators meetings, monthly registered nurse meetings and monthly staff/quality meetings. Meeting minutes include (but are not limited to) a review of the residents using restraints or enablers, updates (if any) to the restraint programme and staff education and training.</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 1.4.2.4</p> <p>The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.</p>	PA Low	<p>There is a fulltime maintenance person who is supported by a part time maintenance person. Maintenance staff undertakes reactive maintenance when it is identified. A reporting system is in place and evidence shows that items identified are addressed.</p> <p>Scheduled and planned maintenance covering all aspects of the facility and equipment is not implemented or documented.</p>	Scheduled and planned preventative maintenance is not routinely undertaken for all aspects of the building and equipment.	<p>Ensure that a programme of scheduled maintenance is undertaken for all aspects of building and equipment.</p> <p>90 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 1.1.9.1</p> <p>Consumers have a right to full and frank information and open disclosure from service providers.</p>	CI	<p>Selwyn Foundation (including Selwyn Heights) has an ethos of open communication. They expect that all staff from domestic staff to management will communicate effectively with residents. This has traditionally been difficult due to the high number of staff for whom English is a second language working at this service. Specific training has been provided around business communication to address this.</p>	<p>In November 2013 the Selwyn Foundation identified from resident and family feedback that not all staff were able to communicate information in a way the residents and families deemed of a high standard. They identified that low numeracy and literacy levels among staff were contributing to this and developed a strategy to improve numeracy and literacy skills for staff, to enhance their work communication skills and also to enhance the lives of staff.</p> <p>In 2014 a pilot ‘business communications’ course was run (the course is a two-hour class over 20 weeks) and following the pilot, the programme was adopted with two programmes running during 2015. A total of 18 Selwyn Heights staff has graduated from the course.</p> <p>The improved communication skills have resulted</p>

			<p>in increased satisfaction ratings in resident and family surveys in the areas of courtesy/friendliness of care assistant, care assistant treat resident with dignity and respect, nurses treat resident with dignity and respect and courtesy and friendliness towards visitors by the nurses. Residents confirmed on interview that these improvements have made a difference in their lives.</p>
<p>Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	CI	<p>In 2014 Selwyn improved the methods to deliver staff training and all staff are now trained using modules. The health, safety and wellbeing module covers safety in the workplace, hazard management, risk management, incident reporting, fire and emergency procedures, moving and handling, management of waste and hazardous substances, wellbeing, bullying and harassment and managing stress for wellness. The person centred care module includes the Selwyn Foundation mission, person centred care, the Eden alternative, Code of Rights, abuse and neglect, advocacy, culturally safe care, sexuality and intimacy, care planning, maximising independence, privacy and dignity and death and dying. The clinical care module covers resuscitation, continence, pain management, skin integrity and wound management, nutrition and hydration, dementia and challenging behaviours and palliative care. The communication and documentation in practice module covers communication, listening skills, documentation, clinical records, principles of clinical documentation – paper based and computerised, messages, incident reporting, hazard reporting, complaints and compliments and responding to feedback and privacy and confidentiality.</p>	<p>Selwyn Foundation has reviewed and changed the ways in which training was delivered in 2014 and 2015. The organisation identified in early 2014 that while staff were attending all mandatory training days, they did not all appear to be implementing the material taught. Investigation into this showed that many staff struggled to learn in large groups.</p> <p>In response to this, core training is now delivered over four modules using a train the trainer method. A trainer's guide, handouts and questionnaires have been developed for each module and Selwyn Heights management or staff has been trained to deliver each module. Each of the modules has been delivered in small groups of four or five staff. Staff interviewed report that they find the new training methods more informative and personalised to their learning style.</p> <p>Following the introduction of the changed training methods, there has been significant gains in the Selwyn Heights satisfaction survey results in questions including technical skills of caregivers and technical skills of nurses.</p>

<p>Criterion 1.3.13.1</p> <p>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p>	<p>CI</p>	<p>The service uses an external contractor to manage the kitchen. The menu is reviewed by a dietitian frequently. The chef manager reported being kept well informed of residents changing dietary needs and this was confirmed by residents and family members interviewed.</p>	<p>Selwyn Heights has introduced a range of measures to manage resident's weight loss with improved outcomes for residents. In April 2015 the service identified that they would like to improve the outcomes for residents with identified weight loss. A number of interventions were implemented including focusing the project on residents that had experienced weight loss in the past three months.</p> <p>Short-term care plans for these residents were introduced that included areas such as dysphasia, oral care and other relevant issues. The food choices of these residents were reviewed including likes and dislikes, the cognitive status of the resident and the time of day at which the resident was most awake to eat meals individually. A food fortification programme was introduced for relevant residents that included fortifying meals the resident were eating to increase calorie intake. All staff received training around this in June 2015 and the programme was described by the chef manager interviewed. Monthly routine weights continued to capture residents at risk of weight loss and when weight loss was identified, the weight management procedure was followed in conjunction with the food fortification programme. Further staff training around weight management was provided in November and December 2015 and March 2016.</p> <p>The programme was reviewed in April 2016 and the five residents on the programme were shown to have gained weight since the programme was introduced. All had either maintained or gained weight each month for the past five months.</p>
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<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>	<p>CI</p>	<p>All residents are assessed at admission and in an ongoing manner to establish interests and skills. A plan is developed for the residents around activities. The activity programme has been reviewed and improved, with resident input, resulting in significantly higher attendance at activities.</p>	<p>In April 2015 the service assessed that attendance levels at activities were low and that this was reflected in the satisfaction with the programme provided. A goal was established to improve the programme as evidence by increased attendance.</p> <p>A new activities coordinator was employed. Residents were encouraged to provide feedback on activities at monthly resident meetings and the programme was adjusted to reflect feedback. Activities now include integration with independent living residents to provide a more community atmosphere, Tai Chi, visits by the clown doctors and cooking classes. Residents in the rest home have been growing their own vegetables, which are cooked and eaten by residents. The service has created a resident friendly garden in the hospital area. Other activities include musical entertainment, spontaneous Devonshire teas, bbq's and cognitive therapy activities.</p> <p>As a result of these activities, attendance has significantly improved. Hospital residents, who previously attended between 35 and 54 activities per month, now attend in excess of 120 activities per month. Rest home residents who routinely attended between 5 and 50 activities per month have increased to between 17 (for a resident who prefers 1:1 engagement) and 85 activities per month.</p>
<p>Criterion 3.5.7</p> <p>Results of surveillance, conclusions, and</p>	<p>CI</p>	<p>When an infection occurs (based on standardised signs and symptoms), an infection control report is completed and provided to the infection control nurse. A short-term care plan is also completed. The infection control nurse keeps a monthly summary</p>	<p>In 2015 the infection control nurse identified that while the infection rate at Selwyn Heights was low compared to other facilities, a reduction in infection rates would benefit residents. The</p>

<p>specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>		<p>log of all infections and all are logged into the online data base for benchmarking. Benchmarking results are provided to staff. A monthly report is provided to the group residential care manager. This includes actions taken, trends identified, proposals and actions indicated to reduce negative trends and analysis of the effectiveness of corrective actions.</p>	<p>project was supported by the Selwyn clinical nurse specialist and the combined Selwyn infection control coordinators.</p> <p>All infections where comprehensively analysed for trends. Actions to reduce negative trends were identified and included staff and resident education, analysis of ideal products to be used and increased fluid rounds in hot weather. The actions were identified, discussed at staff/quality meetings and implemented. In December 2015 a new monthly reporting form was developed and these have been comprehensively completed at Selwyn Heights. The form identifies the types of residents with infections (using sub-grouping), the types of infections, treatments used, trends identified and ongoing improvements implements for each sub-group. The summary section includes details behind the analysis and analysis of improvements previously implemented.</p> <p>As a result of this detailed analysis and addressing of trends, the facility wide infection rate has dropped from seven infections per 1000 bed days in August 2015 to two infections per 1000 bed days in March 2016. The most significant reductions occurred in upper and lower respiratory tract infections and UTI's. In March 2016, two infections were recorded in the entire facility.</p>
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End of the report.