

Selwyn Care Limited - Sarah Selwyn

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: Sarah Selwyn

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

Dates of audit: Start date: 13 April 2016 End date: 14 April 2016

Proposed changes to current services (if any): The service has increased the number of beds by two beds in a large shared room that has previously been occupied by village residents requiring assistance.

Total beds occupied across all premises included in the audit on the first day of the audit: 76



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

Sarah Selwyn is owned and operated by the Selwyn Foundation and provides residential care on the Selwyn Village site for up to 82 residents requiring rest home and hospital level care. On the day of the audit there were 76 residents. This audit has assessed a large double room with an attached ensuite as suitable to provide rest home or hospital level care.

The Sarah Selwyn village manager has both management and aged care experience. The care lead is a registered nurse with experience in aged care management. 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, activities and respect around death, communication, staff training, good practice and family engagement.

This audit has identified an area for improvement around medication documentation.

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.

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.

Services are planned, coordinated and are appropriate to the needs of the residents. A care lead and senior registered nurse 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.		Some standards applicable to this service partially attained and of low risk.
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Service information is provided to residents and family on admission to services. The service utilises a computer based care planning and progress note system. Resident records reviewed provide evidence that the registered nurses utilise the interRAI and paper based assessments to assess, plan and evaluate care needs of the residents. Care plans are developed in consultation with the resident and/or family. Care plans demonstrate service integration and are reviewed at least six monthly. Resident files include three monthly reviews by the nurse practitioner or general practitioner. There is evidence of other allied health professional input into resident care.

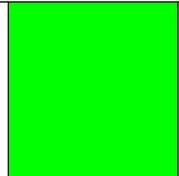
Medication policies reflect legislative requirements and guidelines and medications are recorded using a paper based system. All staff responsible for administration of medicines completes education and medicines competencies. The medicines records

reviewed include documentation of allergies and sensitivities and are reviewed at least three monthly by the general practitioner/nurse practitioner.

A varied activities programme is in place for the rest home and hospital residents. The programme includes community visitors and outings, entertainment and activities that meet the recreational preferences and abilities of the residents.

The menu is designed and reviewed by a registered dietitian and all meals are cooked on-site (in a commercial kitchen) by an external contractor. 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.		Standards applicable to this service fully attained.
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The service displays a current building warrant of fitness. 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.
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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. Eight residents were using restraints and one resident was using an enabler.

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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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 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	4	45	0	1	0	0	0
Criteria	7	93	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>Sarah Selwyn's policies and procedures are being implemented and 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 (eleven caregivers, four registered nurses (RNs), the activities coordinator and the senior RN) confirmed their understanding of the Code. Ten residents (one rest home level and nine hospital level) and three relatives (all hospital 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 give informed consent.</p>	FA	<p>There are standard operating procedures in place for informed consent and resuscitation and the service is committed to meeting the requirements of the Code of Health and Disability Services Consumers Rights. There are signed general consents including outings on all nine resident files sampled (one rest home and eight hospital level of care residents including one resident under the non-weight bearing contract). Resuscitation treatment plans and advance directives were appropriately signed in the files reviewed.</p> <p>Discussions with staff confirmed that they were familiar with the requirements to obtain informed</p>

		<p>consent for personal care and entering rooms.</p> <p>Discussion with relatives confirmed that the service actively involves them in decisions that affect their relative's lives.</p> <p>Informed consent processes are also reviewed through the six monthly multidisciplinary team (MDT) meeting</p>
<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	<p>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. Staff and residents identified the chaplain as an advocate. The resident files include information on residents' family/whānau and chosen social networks.</p>
<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>	CI	<p>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. The service has exceeded the required standard around engaging families and the community in resident's lives.</p>
<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.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p>	FA	<p>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</p>

<p>Consumers are informed of their rights.</p>		<p>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>
<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>	<p>FA</p>	<p>A tour of the premises confirmed there were areas that support personal privacy for residents. During the audit, 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. An annual resident satisfaction survey was completed in July 2015 and the results showed that overall resident experience was reported as being good or very good by 100% of respondents. Residents and relatives interviewed confirmed that staff treat residents with respect.</p> <p>The service has a philosophy that promotes quality of life and involves residents in decisions about their care. Resident preferences are identified during the admission and care planning process and this includes family involvement. Interviews with residents confirmed their values and beliefs were considered. Interviews with caregivers described how choice is incorporated into resident cares.</p> <p>The service has exceeded the standard around the respect to residents and families when a resident dies.</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>	<p>FA</p>	<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. The auditors, the care lead and a Māori resident attended a powhiri during the audit to welcome a group of overseas guests to the village.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture,</p>	<p>FA</p>	<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.</p>

<p>Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>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> <p>Consumers receive services of an appropriate standard.</p>	CI	<p>Policies and procedures are aligned with current accepted best practice. The content of policy and 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 with training for registered nurses from the DHB and involvement in the ACE programme for all caregivers. 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 two registered nurses on each shift. Residents and family described caregivers as being caring and competent. A number of process improvements have been implemented resulting in improvements to resident's wellbeing that exceeds the required standard.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	CI	<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. All 11 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>	FA	<p>Sarah Selwyn is a Selwyn Foundation aged care facility located in Auckland, situated on the Selwyn Village site with four other facilities. The facility is certified to provide rest home and</p>

<p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>		<p>hospital level care for up to 80 residents. This audit has included assessing one large area with two beds as suitable to provide rest home or hospital level care. The area previously only housed independent residents from the village. All rooms are dual purpose.</p> <p>Seventy-six residents were living at the facility during this audit including two on non-weight bearing contracts (medical) and one on a younger person with disability contract. All other residents were on the Aged Related Care contract (one rest home level and seventy-two hospital level). The service intends to provide only hospital level care. One rest home resident remains at the service as it previously provided rest home level care and the resident chooses not to transfer to a rest home service on the site.</p> <p>The organisational strategic plan 2013 to 2017 documents organisational goals. These are reflected in the 2016 Sarah Selwyn business plan which describes the vision, values and objectives of Sarah Selwyn. Annual goals are linked to the business plan and reflect regular reviews via regular meetings.</p> <p>The village manager oversees the entire site and has aged care management and hospitality management experience. The care home is primarily overseen by the care lead who is a registered nurse with aged care experience and has been in the role for two years. The care lead is supported by an assistant village manager, a senior registered nurse and the group residential care manager.</p> <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>
<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>	<p>FA</p>	<p>The assistant village manager and senior registered nurse covers during the temporary absence of the care lead.</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</p>	<p>FA</p>	<p>An established quality and risk management system is embedded into practice. Quality and risk performance is reported across facility meetings and to the residential group manager. Discussions with the managers (group residential care 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>reflects continuous quality improvement principles.</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 very high levels of satisfaction.</p> <p>The service has standard operating procedures (SOP's) and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The service's SOP's 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 SOP's 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, which is utilised for service improvements. Key performance areas are benchmarked against other Selwyn facilities. Quality improvement plans (QIP's) which are monitored for implementation by head office are developed when service shortfalls are identified. For example, a high number of reported pressure injuries in early 2016 resulted in a quality improvement plan which is being implemented to reduce these. Results are communicated to staff at staff/quality meetings and reflected actions are being implemented and signed off when completed.</p> <p>Health and safety policies are implemented and monitored by the health and safety committee. 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</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 11 incident/accident forms (a sample from 10 resident files) 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</p>

manner.		<p>involved in the adverse event process. There is a debriefing process for all critical incidents that includes a staff debrief and a review of the incident at the clinical governance group.</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. Eight appropriate section 31 notifications have been made in 2015 and 2016 including one being investigated by senior management at the time of the audit. All fractures are notified to both HealthCERT and the DHB.</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>Human resources policies include recruitment, selection, orientation and staff training and development. Eight staff files reviewed (the senior registered nurse, one other registered nurse, a domestic worker, the physio assistant, the activities coordinator and three 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>A copy of registered nursing staff and other health practitioner practising certificates is maintained.</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. Some training is 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 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. There are implemented competencies for registered nurses including (but not limited to): medication competencies, restraint competencies, controlled drug competencies and insulin competencies.</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</p>	FA	<p>A policy is in place for determining staffing levels and skills mix for safe service delivery. Rosters implement the staffing rationale. There are five registered nurses (over two floors) on morning shift, three on afternoon shift and two on night shift. A registered nurse from the management team is on call at all times. Activities are provided five days a week. Current staffing is sufficient to cater for the potential two extra residents in the room assessed during this audit.</p>

service providers.		Staff working on the days of the audit 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.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	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 (electronic and paper) 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.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	There are policies and procedures (standard operating procedures) in place around entry to services. The service provides an information pack on entry to the service. Registered nurses assess all residents on entry to the service and information gained is included in the resident records software package. RNs interviewed were able to describe the entry and admission process. The GP is notified of a new admission. Nine signed admission agreements were sighted and all had been signed. The agreement aligns to the service contracts and exclusions from the service are included in the admission agreement.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	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.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and	PA Low	There are comprehensive policies and procedures (standard operating procedures) in place for all aspects of medication management, including self-administration. The RN checks all medications on delivery against the medication and any pharmacy errors are recorded and fed back to the supplying pharmacy. Registered nurses responsible for the administering of medications have completed annual medication competencies and annual medication education. Caregivers who act as a second

<p>safe practice guidelines.</p>		<p>checker also had a medication competency. There was one self-medicating rest home resident on the day of audit. Self-medicating competency, three monthly reviews and monitoring was in place. The two medication rooms were clean and well organised, all medications were in date and stored appropriately. The medication fridges have temperatures recorded daily and these are within acceptable ranges.</p> <p>Eighteen medication charts were reviewed (one rest home and seventeen hospital). Photo identification and allergy status was on all charts. All medication charts had been reviewed by the GP at least three monthly. All resident medication administration signing sheets corresponded with the medication chart. Not all medication charts evidence full and comprehensive documentation of non-packaged regular medication orders.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>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 in the commercial kitchen that provides for all the facilities on the site.</p> <p>The external contractors have 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 special dietary needs have these needs identified. Resource information on these diets is available in the kitchen and via the dietitian. Resident forums discuss food and feedback is given. The service has exceeded the required standard around meeting the nutritional needs of residents with weight loss.</p> <p>Residents interviewed praised the meals.</p> <p>Special equipment is available such as lipped plates/assist cups/grip and built up spoons and on observing mealtimes it was noted there were sufficient staff to assist residents.</p> <p>The kitchen was observed to be clean and well organised and all aspects of food procurement, production, preparation, storage, delivery and disposal complied with current legislation and guidelines.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is</p>	<p>FA</p>	<p>The reason for declining service entry to residents to the service is recorded and should this occur, the care lead stated it would be communicated to the resident/family and the appropriate referrer. Potential residents would only be declined if there were no beds available or they did not</p>

declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.		meet the service requirements.
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>The facility has embedded the interRAI assessment protocols within its current documentation. InterRAI initial assessments and assessment summaries were evident in printed format in all files. The computer software includes a wide range of assessments that are used to develop the care plan. InterRAI assessments are also used to develop the care plans. Eight of nine resident files included an up-to-date interRAI assessment (one was a DHB contract resident) and all nine had a full suite of computer based assessments. In all cases, assessments were reflected in to care plans</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>	FA	<p>The resident files reviewed were resident focused, integrated and promoted continuity of service delivery. The facility uses an integrated computer software system where the GP, allied services, the RNs, activities coordinators, physiotherapist and other visiting health providers write their care notes in the resident file on the computer.</p> <p>Eight of nine residents have had a computer based, in-depth nursing care plan, a care plan summary and short-term care plans as needed. The service had an appropriate amount of computer terminals in the nurse's stations (upstairs and downstairs). Both RNs and caregivers interviewed stated they have free access to the resident files. This was also observed on the days of audit. The DHB resident had paper based care plans.</p> <p>All resident care plans were resident focused. Family members interviewed agreed that they had been involved in the care planning development and review process. Short-term care plans were in place for acute and short term conditions and had been evaluated on a regular basis.</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</p>	FA	<p>When a resident's condition changes the RN initiates a GP visit or nursing specialist referral. Residents interviewed reported their needs were being met. Family members interviewed stated the care and support met their expectations for their relative. There was documented evidence of relative contact for any changes to resident health status.</p> <p>Continence products are available and resident files include a three-day urinary continence</p>

<p>outcomes.</p>		<p>assessment, bowel management and continence products identified for day use, night use and other management. Specialist continence advice is available as needed and this could be described by the RNs interviewed. Caregivers and RNs interviewed state there is adequate continence and wound care supplies.</p> <p>Wound care plans were paper based and included an assessment, wound management and evaluation forms. Short-term care plans were computer based and documented regular review. Nineteen wounds were documented on the day of audit: twelve skin tears, (five residents have more than one skin tear), one blister, an infected toe, one chronic ulcer and a surgical wound. There were three pressure injuries.</p> <p>Monitoring charts were in use and examples sighted included (but not limited to): weight and vital signs, blood glucose, pain, food and fluid, turning charts and behaviour monitoring as required.</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>Selwyn Village employs a full-time, trained diversional therapist who assists and oversees the individual service centres.</p> <p>Sarah Selwyn employs two activities coordinators who both work full-time. Activities are provided five days a week and music recitals, movies and church services are arranged for the weekends. A wide range of activities, addressing the abilities and needs of residents in the hospital and rest home, were offered. Activities included physical, mental, spiritual and social aspects of life to improve and maintain residents' wellbeing. The programme timetable was available to all, along with additional material promoting specific activities to encourage residents to join in.</p> <p>The service is active with the Eden philosophy and this was evident through the smaller home like resident bays. Residents were observed taking part in the day-to-day service (such as assisting with meals and gardening).</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 completed monthly. Reviews are conducted six monthly (or earlier should the residents condition determine) as part of the care plan evaluation/review. The resident/family/EPOA as appropriate is involved in the development of the activity plan.</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. Some of those included in activities offered are Christian groups, trips to local restaurants, pet therapy, musicians, yoga and Tai Chi. There are volunteers that assist with a variety of activities including van outings.</p>

		<p>The service has exceeded the standard around activities provided.</p> <p>Residents and families interviewed confirmed the activity programme was developed around the interest of the residents. 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>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The resident files reviewed showed long-term care plans had six monthly reviews completed and were updated when needs changed. Clinical reviews were documented in the multidisciplinary review (MDR) records, which included input from the GP, RNs, activities coordinators, 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 from specialist practitioners. The review of resident folders included evidence of recent referrals.</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 infection control manual contains documented policies and procedures for the safe and appropriate storage and disposal of waste and hazardous substances. The health and safety manual includes policy around safe storage and handling of chemicals. Waste is appropriately managed.</p> <p>Chemicals are secured in designated locked cupboards. Chemicals are labelled and safety data sheets were available throughout the facility and accessible to staff. Chemicals were observed to be secured safely. Safe chemical handling training has been provided. Personal protective equipment/clothing is freely available.</p> <p>Staff interviewed 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>FA</p>	<p>The building has two levels. The building holds a current warrant of fitness which is displayed. Fire drills occurs six monthly. There is a maintenance work notification book for staff to communicate with maintenance staff on issues and areas that requires attention. A preventative maintenance schedule is in place for the service. Hot water temperatures are monitored and recorded monthly. Electrical equipment is tested and tagged. All hoists have been checked and serviced and medical equipment has been calibrated and checked. The facility vans are registered and each has a current warrant of fitness.</p> <p>Residents were observed moving easily around the building with walking aids, wheelchairs and independently.</p> <p>There are outside courtyard areas with seating, tables and shaded areas that are easily accessible. All hazards have been identified in the hazard register.</p> <p>Two additional care beds in one shared room were reviewed. They are in a small separate annex, close to other resident rooms. Privacy is maintained with a room divider. The room is easily accessible for residents and associated mobility aids as needed and suitable to provide rest home or hospital level care.</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 communal 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 a system that indicates if it is engaged or vacant. Privacy is further maintained by additional curtains behind doors in some areas. The new shared room has a shared mobility aid accessible toilet and bathroom. This room was previously a small lounge that had been used for independent village residents and is near the entrance of the service (within the building)</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, including the two new care rooms. Transfer of residents can occur on an ambulance stretcher and equipment can be transferred 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 Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>The service has a number of communal lounge/dining areas on both floors of the building. There are smaller seating areas for residents and families around the facility. Furniture in all areas is arranged to allow residents to freely mobilise. Residents and families interviewed agreed that the service is spacious and residents may stay in their own wings or join in any of the communal lounges.</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>	FA	<p>All laundry is completed off-site except some rest home personal items. Residents and relatives expressed satisfaction with cleaning and laundry services. The service has secure cupboards for the storage of cleaning chemicals. 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>	FA	<p>There is at least one staff member on duty at all times with a first aid certificate. 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>Emergency equipment, water and food are available.</p> <p>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. 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>	FA	<p>Resident's rooms, including the new two-bed care room, are provided with adequate natural light, safe ventilation and in 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>Sarah Selwyn 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. A registered nurse is the designated infection control nurse with support from the care lead and staff through the quality meeting acting as 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>A registered nurse at Sarah Selwyn 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 for staff has occurred. 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</p>

consumers.		and visitors that is 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>	FA	<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>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 justified 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 was one resident using an enabler (a lap belt) and eight residents with restraints (four bedrails, one mittens, two brief restraints and one lap belt).</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 providers and others.</p>	FA	<p>The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator (senior 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>
Standard 2.2.2: Assessment	FA	A restraint assessment tool is completed for residents requiring an approved restraint for safety.

<p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>		<p>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 were 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 Services use restraint safely</p>	<p>FA</p>	<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>Restraint authorisation is in consultation/partnership with the resident, family and the GP. 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 Services evaluate all episodes of restraint.</p>	<p>FA</p>	<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 Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<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. There are six current residents at the service who have had restraint reviewed and removed.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.12.6</p> <p>Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.</p>	PA Low	<p>Eleven of nineteen medication charts reviewed met legislative requirement. Discontinued medications were dated and signed by the NP/GP. All ‘as required’ medications had an indication for use.</p>	<p>Eight medication charts (all hospital) did not have the time for administration documented (for non-packaged regular medication orders) on the medication form, with GPs only documenting how many times a day the medication was to be given.</p>	<p>Ensure the medication charts document when the medications should be administered.</p> <p>60 days</p>

Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, 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
Criterion 1.1.12.1 Consumers have access to visitors of their choice.	CI	Sarah Selwyn has always had a philosophy of the importance of supporting and encouraging families and others to visit the service. Over 2014 and 2015 they have provided a number of initiatives to encourage family and community members of all ages to visit the residents of the service.	<p>Sarah Selwyn identified in 2014 that resident’s lives would improve if family members of all ages (and friends and other community members) felt very welcome and comfortable when they visited and set a goal to improve the experience for those visiting the facility.</p> <p>A number of initiatives and events have been implemented including interactive displays at the entrance (e.g., post a letter to Santa and receive a small gift, write on a cut out figure a comment about why your mother/father (not just residents) are special and other displays), developing a children’s play area with modern clean tools in each of the main lounges, providing free Wi-Fi to visitors (signs around the facility clearly advertise this), holding a surprise fair day in the format of an old fashioned school fair with fair games, toffee apples etc. (entry was free), holding children’s</p>

			<p>colouring competitions and a birthday party to celebrate the anniversary of Sarah Selwyn opening which 60 visitors attended (and including visiting farm animals and face painting) in February 2016.</p> <p>As a result of the focus on improving the experience for visitors, the overall survey results in the family and visitors' sections have increased (Sarah Selwyn is now in the 90th percentile) and the reported courtesy and friendliness toward visitors now rates at 95%. Seven of ten residents interviewed provided unsolicited comments on the friendly environment for those visiting, as a strength of the service.</p>
<p>Criterion 1.1.3.2 Consumers receive services that are responsive to the needs, values, and beliefs of the cultural, religious, social, and/or ethnic group with which each consumer identifies.</p>	CI	<p>The service provides services that are individualised and focus on dignity and respect. Following feedback from resident's staff and families around the difficult time when resident's die, a number of initiatives improved this process and exceed the required standard.</p>	<p>Over late 2014 and 2015 personal communication with families, residents, staff and the management team identified that all felt that when a resident died, this was respectfully acknowledged. However, the body was often removed without other residents and families knowing. Staff were uncertain when rooms had been blessed and were also grieving. Families and residents were often not able to attend funerals (due to health, private funerals or other commitments).</p> <p>A project was established to manage the after death process of a resident in a manner that was more respectful to the staff, residents and family members of residents who had grown close to the resident. The project involved bedroom doors being left open after a deceased resident was ready for viewing (providing the family of the deceased resident consented) so that the residents and staff could see the deceased resident if they wished and not feel the 'body' was shut away in a room alone. When the funeral directors arrive to collect a deceased resident, staff, residents and families that are at the facility are invited to the entry/exit area to farewell the person. After a room has been blessed a butterfly picture is placed on the door</p>

			<p>to indicate to all that the room has now been blessed. A memorial service was held in late 2015 that was attended by the families of 13 residents who had passed away during the year (the families of all residents deceased in the past year were invited and all current residents and their families were invited). A total of around 100 people attended the service which is now to be an annual event.</p> <p>Following these changes, the service has received 13 unsolicited compliments around the respect with which the process of a resident dying is managed at Sarah Selwyn.</p>
<p>Criterion 1.1.8.1 The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>Sarah Selwyn provides a culture of continuous improvement. Quality improvement plans are developed when shortfalls are identified (complaints, critical incidents, internal audits or observations) and also when an opportunity is identified for improvement to services (complaints, ideas, critical incidents, suggestions).</p>	<p>Sarah Selwyn provides examples of continuous improvement and has a goal to continually improve the service provided to residents and their families. Staff, families and management are encouraged to provide suggestions and ideas that could improve resident's lives. Ideas are actively sought at staff meetings and these are documented on quality improvement plans (QIP's) and a plan to implement the idea is developed where this is practical.</p> <p>Examples include the suggestion of an improved hi fi system that was portable and could be moved between resident areas, the purchase of a robot seal (Paro) to engage with residents who are not actively engaged in other interaction and the introduction of short toolbox talks for staff around areas to improve the lives of residents. A caregiver whose confidence increased after attending the Selwyn Business Communication course (link 1.1.9.1) studied cognitive stimulation therapy and commenced a cognitive stimulation therapy group for seven residents. Engagement was measured weekly around four areas for each resident (interest, communication, enjoyment and mood) and there has been a significant increase in the ratings</p>

			<p>from mostly ones and twos in early April when the group began to fours and fives for many of the residents attending.</p> <p>As a result of the overall quality improvement initiatives at the facility, already high survey outcomes in 2013 have increased to 100% of families and 100% of residents rating the overall service as good or very good in July 2015.</p>
<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 Sarah Selwyn) 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 16 Sarah Selwyn staff have graduated from the course.</p> <p>The improved communication skills have resulted in increased satisfaction ratings in resident and family surveys in the areas of courtesy/friendliness of care assistants, care assistants treat residents with care and respect, staff response to activity ideas, courtesy and friendliness towards visitors, staffing keeping respondents informed, staff providing emotional support and helpfulness of staff arranging services.</p>
<p>Criterion 1.2.7.5</p>	CI	<p>In 2014 Selwyn improved the methods to deliver staff training and all staff are now trained using modules. The</p>	<p>Selwyn Foundation has reviewed and changed the ways in which training was delivered in 2014 and 2015.</p>

<p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>		<p>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>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. The 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 Sarah Selwyn management or staff has been trained to deliver each module. Each of the modules has been delivered to staff in small groups of four or five staff.</p> <p>Staff interviewed report that they find the new training methods more informative and personalised to their learning style. Following the introduction of the changed training methods, there has been significant gains in the Sarah Selwyn satisfaction survey results in questions including technical skills of caregivers and technical skills of nurses.</p>
<p>Criterion 1.3.13.1 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>Meals at Sarah Selwyn are cooked by a contracted company in a commercial kitchen in another complex on-site. Registered nurses assess the dietary needs of all residents and referral to a dietitian is initiated as appropriate. The kitchen staff are informed of all dietary requirements.</p>	<p>The service identified that they needed to identify residents at risk of malnutrition and provide early intervention in order to ensure the risks associated with unintended weight loss could be minimised.</p> <p>The serviced linked with the external catering company to introduce the 'Replenish Energy and Protein (REAP). The action plan included training for kitchen and Selwyn staff, consulting with an external dietitian and providing additional staff to assist with meals. Resident at risk of malnutrition were commenced on the REAP diet programme and their weight monitored over time.</p> <p>Nine residents on the programme all gained weight over a period of six months.</p>

			The programme has been extended for all residents at risk of malnutrition.
<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>All residents are assessed at admission and in an ongoing manner to establish interests and skills and a plan is developed for the residents around activities. The activity programme has been reviewed and improved with resident input. This has resulted in significantly higher attendance at activities and very positive verbal and written feedback expressed to the service.</p>	<p>The resident survey 2013 reported to the service that satisfaction with the activity programme was low (71.8%). A goal was established to improve the programme.</p> <p>In 2014 a new care lead was employed who empowered therapists and staff to implement more varied and detailed activities for the residents. In 2015, Selwyn village employed a diversional therapist who has an oversight position for all of the care homes in the village. Between the care lead, the DT and in consultation with staff and residents the following was put in place:</p> <p>Residents were encouraged to provide feedback on activities at monthly resident meetings and the programme was adjusted to reflect feedback. They are also weekly activity team meetings to review activities that have taken place and plan for the future. Activities now include integration with independent living residents to provide a more community atmosphere. Tai Chi and Zumba, visits by the clown doctors, art therapy – now led by a gifted resident, musical entertainment that includes residents, cognitive therapy activities and formal discussion groups (such as the flag debate). Cooking classes now include staff cooking from their own culture and sharing with residents.</p> <p>As a result of these activities, satisfaction has improved significantly – in 2015 the satisfaction had improved from 71.8% to 79.4 %.</p>

End of the report.