

Selwyn Care Limited - Kerridge House

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:	Kerridge House
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 29 March 2017 End date: 30 March 2017
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:	58

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 Kerridge House is owned and operated by the Selwyn Foundation and is one of four services operating from the village site. The service provides care for up to 60 residents requiring rest home or hospital level care. On the day of the audit there were 58 residents.

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 aged care facilities on the site, including Selwyn Kerridge House are overseen by a village manager, who has been in the position for six years. Selwyn Kerridge House is managed by a care lead, who is a registered nurse (RN) and has been in the role for twelve months and has worked at the Selwyn Foundation for seven years. The care lead is supported by a team of registered nurses.

The service has exceeded the standard around infection surveillance and activities. This audit has identified areas for improvement around: complaints management; completion of quality improvement plans; wound management; and aspects of medication management.

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.		Some standards applicable to this service partially attained and of low risk.
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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 receive ongoing training about the Code. The personal privacy and values of residents are respected. Individual care plans reference the cultural needs of residents. Discussions with residents and relatives confirm 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. There is an established system for the management of complaints.

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.		Some standards applicable to this service partially attained and of low risk.
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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. The service has a quality and risk management programme in place. Data is collected, analysed, discussed and changes made as a result of trend analysis. 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. Residents and families report that staffing levels are adequate to meet the needs of the residents.

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 medium or high risk and/or unattained and of low risk.
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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. Long-term care plans are developed by the service's registered nurses, who also have the responsibility for maintaining and reviewing the care plans.

InterRAI assessment tools and monitoring forms are used to assess the level of risk and ongoing support required for residents. Care 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.

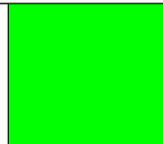


Standards applicable to this service fully attained.

The service displays a current building warrant of fitness. Proactive and 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. Incidents are reported on in a timely manner. 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 receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and policies for the safe assessment, planning, monitoring and review of restraint and enablers. A register is maintained by the restraint coordinator. There are two residents with restraints and one resident 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.

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. The programme 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	1	45	0	2	2	0	0
Criteria	2	95	0	2	2	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>The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in a visible location. Families and residents are provided with information on admission which includes information about the Code. Staff receive training about resident rights at orientation and as part of the annual in-service programme. Interviews with fifteen care staff (ten caregivers, four registered nurses (RN) and one diversional therapist) confirms their understanding of the Code. Six residents (four rest home and two hospital level) and five relatives (three rest home and two hospital level) interviewed confirm 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>The service has policies and procedures relating to informed consent and advanced directives. All resident files reviewed included signed informed consent forms and advanced directive instructions. Staff are aware of advanced directives. Admission agreements are in place and have been signed by the resident or nominated representative. Discussion with residents and families identified that the service actively</p>

		involves them in decision making.
<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 confirm that they are aware of their right to access independent advocacy services. Relatives confirm that the service provides opportunities for the family/EPOA to be involved in decisions. 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 confirm open visiting hours. 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>	PA Low	Complaints policy and procedures are in place and residents and their family/whānau have been provided with information on admission. Complaint forms are available at the service. Residents confirm that they received information on the complaints process on admission and the care lead is very approachable should they have any concerns/complaints. Care staff interviewed are aware of the complaints process and to whom they should direct complaints. A complaints folder has been maintained. There have been sixteen complaints received in 2016 and two made in 2017 year to date. Six of the sixteen complaints made in 2016 did not have any documented follow up, investigation or outcome resolutions.
<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 confirm that information had been provided to them around the Code. Large print posters of the Code and advocacy information are displayed throughout the facility. The care lead or senior RN 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 confirms that there are areas that support personal privacy for residents. Staff respect residents' privacy by knocking on doors prior to entering resident rooms. Staff could describe definitions around abuse and neglect. Relatives interviewed confirm that staff treat residents with respect. 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.</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 and within New Zealand. It provides recognition of Māori values and beliefs. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. The Selwyn Foundation works with their Tikanga partner through Te Pihopatanga O Te Taitokerau, which caters for all iwi. At the time of the audit, there were no residents that identified as Māori living at the facility.</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 family/whānau as appropriate are invited to be involved. Individual beliefs and values are discussed and incorporated into the care plan. Six-monthly multidisciplinary team meetings occur to assess if needs are being met. Discussions with relatives confirms 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/quality 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 (group residential care manager, village manager and care lead) 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 procedures are sufficiently detailed</p>

<p>Consumers receive services of an appropriate standard.</p>		<p>to allow effective implementation by staff. 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 monthly staff/quality meetings. Residents and family interviewed advised that caregivers are caring and competent.</p>
<p>Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</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. Fifteen of fifteen incident/accident reports reviewed meet this requirement. Relatives interviewed confirm they are notified following a change of health status of their family member. There is an interpreter policy in place and contact details of interpreters are available.</p>
<p>Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Selwyn Kerridge House is owned and operated by the Selwyn Foundation and is one of four services operating from the village site. The service provides care for up to 60 residents requiring rest home or hospital level care. On the day of the audit there were 58 residents. Thirty-nine were rest home residents (including one palliative care resident) and nineteen hospital level residents. There are 24 dual purpose beds in the hospital wing. All residents are under the Aged Related Residential Care (ARRC).</p> <p>The aged care facilities on the site, including Selwyn Kerridge House are overseen by the village manager, who has been in the position for three years. Selwyn Kerridge House is managed by a care lead, who is an RN and has been in the role for twelve months and has worked at the Selwyn Foundation for seven years. The care lead is supported by a senior RN and five other RNs.</p> <p>The Selwyn Foundation has an overarching five-year strategic plan 2013 to 2017 which includes the new model of care ‘The Selwyn Way’ which underpins how the Selwyn Foundation operates within the context of its mission. The strategic plan also includes the organisational goals and these are reflected in the 2016-2017 Selwyn Kerridge business plan, which describes the vision, values and</p>

		objectives of Selwyn Kerridge House. Annual goals are linked to the business plan and reflect regular reviews via regular meetings.
<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 care lead from Sarah Selwyn 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>	PA Low	<p>There is an established quality and risk management system in place. Quality and risk performance is reported across facility meetings and to the group residential care manager. Discussions with the managers, the GP and staff reflect staff involvement in quality and risk management processes. Resident meetings are completed monthly. Meeting minutes are maintained. Annual resident and relative surveys are completed with results communicated to residents and staff. In 2016, the Selwyn Foundation completed a communication resident/relative survey to gain an understanding of the communication levels within the Selwyn Village.</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 include procedures around the implementation of interRAI. The internal audit schedule for 2016 has been completed and 2017 is underway. Twelve internal audits that were not compliant, did not have corrective actions in place or are not signed off as completed.</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. Key performance areas are benchmarked against other Selwyn facilities.</p> <p>Health and safety policies are implemented and monitored by the Health and Safety Committee. The Selwyn Foundation Health and</p>

		<p>Safety Committee meet on a monthly basis. Risk management, hazard control and emergency policies and procedures are in place. A health and safety representative (caregiver) was interviewed about the health and safety programme. 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 perimeter guard mattress covers.</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. A review of fifteen incident/accident forms from March 2017, identified that forms are fully completed and include follow up by an RN. Neurological observations are completed for any suspected injury to the head. The care lead and senior RN are involved in the adverse event process. The group residential care manager was able to identify situations that would be reported to statutory authorities.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Human resources policies include recruitment, selection, orientation and staff training and development. Six staff files reviewed (one care lead, one RN, three caregivers and one cleaner) document a recruitment process which include: reference checking, signed employment contracts and job descriptions, completed orientation programmes and annual performance appraisals. 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</p>

		<p>required trainings. Aspects of training are provided during full day training sessions. There is an attendance register for each training session and an individual staff member record of training.</p> <p>Four of six registered nurses have completed interRAI training and have maintained their competency.</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. The care lead (RN) works full-time Monday to Friday and is available on call 24/7. She is supported by a senior RN. There is a registered nurse on duty on each shift. The registered nurses are supported by sufficient numbers of caregivers. Care staff levels are: seven caregivers in the AM shift plus a senior supervising caregiver (three in the rest home and four in the hospital); six caregivers in the PM shift plus a senior supervising caregiver (two in the rest home and four in the hospital) and two caregivers at night (one in the rest home and one in the hospital).</p> <p>Staff are visible and attend to call bells in a timely manner as confirmed by all resident and relatives interviewed. Staff interviewed state that overall the staffing levels are satisfactory and that the managers provide good support. Residents and relatives interviewed report there are sufficient staff numbers. Selwyn Foundation has its own bureau of nursing staff to cover sick leave and annual leave.</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 are appropriate to the service type. Residents entering the service have all relevant initial information recorded in their individual record within 24 hours. 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. 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>The admission handbook outlines access, assessment and the entry screening processes. The service operates twenty-four hours a day, seven days a week. Comprehensive information about the service is made available to referrers, potential residents and their families. Resident agreements sighted contain all detail required under the Aged Residential Care Agreement. Family members and residents</p>

		interviewed state that they have received the information pack and have received sufficient information prior to and on entry to the service. Family members report that the clinical lead is available to answer any questions regarding the admission process.
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 a policy that describes guidelines for death, discharge, transfer, documentation and follow up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. The Auckland District Health Board yellow envelope initiative is used to ensure the appropriate information is received on transfer to hospital and on discharge from hospital back to the facility. Communication with family is made. One file reviewed was of a resident that had been transferred to hospital acutely. All appropriate documentation and communication had been completed. Transfer to the hospital and back to the facility post-discharge is well documented in progress notes.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate	The medication management policies and procedures comply with medication legislation and guidelines. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Resident's medicines are stored securely in the medication room/cupboards. Medication administration practice complies with the medication management policy for the medication round sighted. There is evidence of three-monthly reviews by the GP. Registered nurses and care supervisors administer medicines. All staff that administer medicines are competent and have received medication management training. Sixteen individual resident's paper medication charts were sighted. Resident medication charts are identified with photographs and allergies are recorded. Not all prescribed 'as required' medications document the indication for use. Not all medications are evidenced to be administered as prescribed. The facility uses a robotically packed medication management system for the packaging of all tablets. The RN on duty reconciles the delivery and documents this. Temperature monitoring of the medication fridges is completed daily. There are two residents self-administering medication currently. A competency to assess the residents continued ability to self-administer has been completed and has been reviewed by the GP at the three-monthly

		<p>medication review. The residents have a locked drawer in their room for safe storage of medication.</p> <p>One hospital resident was prescribed and administered subcutaneous fluids during the days of audit. Fluid balance charts had been completed and four-hourly monitoring of the subcutaneous administration site and set had been completed and signed by a registered nurse.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>Food is prepared off-site at The Selwyn Foundations' main centralised kitchen. The food services are provided by a contracted catering company. An eight-weekly rolling menu is implemented and changes seasonally. The main kitchen caters for all Selwyn Foundation sites, the village and café. The chefs have completed NZQA modules 167 and 168. Dietitian review of the menu was completed in February 2017. A food safety plan is implemented. A copy of residents' nutritional profiles is sent to the main kitchen and also a copy is kept in the kitchen serveries on-site. The kitchen has a comprehensive system whereby they are kept current with changing needs of the residents.</p> <p>The food is transported to the facility in insulated hot boxes and transferred into bain maries. All staff handling food have food handling certificates. Food temperatures are taken before leaving the main kitchen and upon arrival and before service. The receiving kitchen also holds sandwiches, biscuits, soup and fruit which can be utilised for residents over a 24-hour period and supplies are replenished daily.</p> <p>There is evidence of modified diets being provided (eg, diabetic, soft and pureed textured meals) and further nutritional supplements. Residents with weight loss are reviewed and are placed, if appropriate, on the REAP programme – Replenish Energy and Protein food fortification. Residents can choose to have breakfast in bed or in the dining room. A buffet breakfast with flexible times is in place promoting choice and independence. Staff were observed assisting those residents who require help with food and fluid intake. Lipped plates, sipper cups and adapted cutlery are available and observed in use.</p> <p>The kitchen manager attends the monthly resident meetings and is provided with feedback regarding the meal service. Residents interviewed spoke positively regarding the meal service.</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>There is policy in place regarding the process for declining entry. Consumers are declined entry when there are no beds available, or if the person has health needs that are not able to be provided by the facility. If a potential admission was declined entry, the consumer and where appropriate their family/whānau of choice, is informed of the reason for the decline and are asked to contact Older Persons Health at Auckland DHB.</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>InterRAI initial assessments and reviews are evident in printed format in all resident files. Electronic resident files reviewed identify that risk assessments have been completed on admission and reviewed six-monthly as part of the evaluation. Additional assessments for management of behaviour, pain, wound care, nutrition, depression score, falls and other safety assessments including restraint are appropriately completed according to need. For the resident files reviewed, the outcomes from assessments and risk assessments are reflected into care plans.</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 sampled are resident-focused and personalised. The care plans describe the resident goals, supports and interventions required to meet desired goals as identified during the ongoing assessment process. There is documented evidence of resident and/or family input ensuring a resident focused approach to care. Residents confirmed on interview they are involved in the care planning and review process. There is evidence of allied health care professionals involved in the care of the resident. Long-term care plans sampled have been reviewed and updated in a timely manner following a decline in health. Acute care needs support care plans are evident in the sampled files and developed following a change in health. Interventions documented are sufficiently detailed to address the desired outcome/goal. Integration of records and monitoring documents are managed well.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Moderate</p>	<p>Registered nurses (RNs) and caregivers follow the care plan and report progress against the care plan each shift at handover. If external nursing or allied health advice is required, the RNs will initiate a referral (eg, to the district nurse or wound care specialist nurse). If external medical advice is required, this will be actioned by the GP. Staff have</p>

		<p>access to sufficient medical supplies (eg, dressings). Continence products are available and resident files include a continence assessment and plan as part of the plan of care. Specialist continence advice is available as needed and this could be described.</p> <p>Wound assessment, treatment and wound management plans are completed for all wounds. On the day of audit there were ten wounds. There are two wound care folders in use (one for RNs and one for wound dressings carried out by the care supervisor). There is evidence of duplicate wound assessments in each folder. On discussion with the care lead and a review of both wound care folders, it was established that the current wounds being treated include: four skin tears, one open haematoma, one infected skin lesion, one lesion, two chronic vascular leg ulcers and one healed stage II pressure injury (protective dressing in place).</p> <p>Not all wounds have been reviewed within the prescribed timeframes. Where multiple wound management plans are on file for chronic wounds, it was difficult to establish which is the current treatment plan. All wounds evidence progress towards healing with the exception of two chronic vascular ulcers. GP and wound nurse specialist input into care is documented for chronic wounds. Interviews with registered nurses and caregivers demonstrated an understanding of the individualised needs of residents. Monitoring charts sighted include: behaviour charts, turning charts, food and fluid charts, regular monitoring of bowels and regular (monthly or more frequently if required) weight management.</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 confirms that independence is encouraged and choices are offered to residents. The activity coordinator and assistants at Selwyn Kerridge House deliver the programme. The programme runs over seven days per week. The Selwyn Foundation diversional therapist assists with the programming and mentors and supports all activity coordinators and assistants. A wide range of activities, addressing the abilities and needs of residents in the rest home and hospital are provided.</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</p>

		<p>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 confirm that the activities are enjoyed and they are very satisfied with the activities programme. Activities include outings as well as community involvement.</p> <p>A monthly meeting is held where residents and relatives have input. Minutes are recorded at the meeting and 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>Care plans reviewed have been evaluated by registered nurses six-monthly to assess achievement towards the desired goal, or when changes to care occurred. Acute care needs support care plans for short-term needs are evaluated and either resolved or added to the long-term care plan as an ongoing need. The six-monthly multidisciplinary review involves the RN, GP, activities staff, physiotherapist (if involved) and resident/family. The family are notified of the outcome of the review by phone call and if unable to attend, they receive a copy of the reviewed plans. There is at least a three-monthly review by the medical practitioner. The family members confirm they are invited to attend the care plan reviews and GP visits.</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>Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The clinical lead gave examples of where a resident's condition had changed and transfer to hospital was required or where a resident was reassessed as requiring dementia level care. Discussion with the clinical lead and registered nurses identifies that the service has access to a wide range of support either through the GP, The Selwyn Foundations own specialists and the Auckland City Hospital.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous</p>	FA	<p>The service has documented policies and procedures for the safe and appropriate storage and disposal of waste and hazardous substances.</p>

<p>Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>		<p>Waste is appropriately managed.</p> <p>Chemicals are secured in designated locked cupboards. Chemicals are labelled and safety data sheets are available throughout the facility and accessible to staff. Safe chemical handling training has been provided. Personal protective equipment/clothing is available 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>FA</p>	<p>The building holds a current warrant of fitness, which expires 28 May 2017. The building is single storey and divided into two wings. Twenty-four beds in the hospital (Banyard wing) are dual purpose. The Selwyn Foundation employs a full-time property manager and three maintenance officers. There are proactive and reactive maintenance management plans in place. Contracted providers test equipment. Electrical testing of non-hard wired equipment was last conducted on 8 November 2016. Medical equipment requiring servicing and calibration was last conducted in December 2016. There are hazard management systems in place to ensure the physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the residents and any visitors or contractors to the facility. Residents have adequate internal space to meet their needs. External areas are safe and well maintained. The facility has a van available for transportation of residents. Those transporting residents are designated drivers.</p> <p>Two days prior to the audit, the facility had experienced a water leak causing damage to hallway carpet in the rest home area. The hazard has been identified and maintenance are aware. Hazard warning signs are in place warning of the change in floor level as a large piece of damaged carpet has been removed and the floor needs to dry out before being repaired. Residents, staff and visitors interviewed are aware of the hazard.</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</p>	<p>FA</p>	<p>There are adequate toilets and showers for residents. Separate visitor and staff toilet facilities are available. Water temperatures are monitored and temperatures are maintained at or below 45 degrees Celsius. Records sighted evidenced that corrective actions are implemented and evaluated when temperatures are above the target</p>

personal hygiene requirements.		range. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	Resident rooms are spacious. Walking frames, wheelchairs and hoists can be manoeuvred around the bed within the rooms, if required. Residents requiring transportation between rooms or services can be moved from their room either by trolley or by wheelchair.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	There is a large lounge/dining area. There are several other lounge areas in each wing which can be used for activities or for residents to access when they want some quiet/ private time with family or friends. There are garden areas and courtyards which contain seating and shade. There are raised garden planters and vegetable gardens which are easy for residents to access for gardening.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	All laundry is completed at the centralised laundry located on The Selwyn Foundation site. Laundry is picked up and delivered daily. There is a laundry on the premises which provides a clean area for delivery and folding of resident's personal laundry. There is a separate storage area for pickup of dirty 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.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	There is an emergency response and civil defence plan to guide staff in managing emergencies and disasters. Emergency response and first aid is included in the mandatory in-service programme. There is a first aid trained staff member on every shift. Staff records sampled document current training regarding fire, emergency and security education. A letter from New Zealand Fire Service dated 1 November 1999 advises approval of fire evacuation schemes. The last trial evacuation was held on 14 October 2016. Information in relation to emergency and security situations is readily available/displayed for service providers and residents. Two civil defence kits include (but not limited to): torches, extra food supplies,

		<p>blankets, batteries and cell phones. There is a gas barbeque should the mains gas supply fail. The service has adequate stored water including water tanks for an emergency. An appropriate call bell system that is easily used by the resident or staff to summon assistance if required. Call bells are within easy reach and are available in resident areas (eg, bedrooms, ensuites, the lounge and dining room).</p> <p>CCTV cameras have been installed to monitor main corridors and exits, these do not impinge on resident privacy. A security company monitors the facility overnight. External doors are locked overnight during the hours of darkness.</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>The facility is light and airy and able to be ventilated by opening external windows and doors. There is electric heating with heat pumps and air conditioning installed in public areas. Internal temperatures are monitored and regulated by the maintenance team.</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 Kerridge House 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 Foundation key performance indicators. A registered nurse is the designated infection control coordinator with support from the care lead. Meetings are conducted monthly. 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 infection control programme is reviewed annually. There have been no outbreaks since the previous audit.</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>There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The infection control coordinator (registered nurse) and Infection Control Committee (team) has good external support from the local laboratory infection control team and IC nurse specialist at the DHB and internal support from The Selwyn Foundation infection control nurse specialist. 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</p>

		gel is freely available.
<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	The infection control manual outlines a comprehensive range of policies, standards and guidelines and defines roles, responsibilities and oversight, the infection control team, training and education of staff and scope of the programme.
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	The infection control coordinator is responsible for coordinating/providing education and training to staff. The orientation package includes specific training around hand washing and standard precautions. The infection control coordinator has completed education through an external provider to enhance her skills and knowledge. The infection control coordinator has access to The Selwyn Foundation intranet with resources, guidelines best practice and group benchmarking. A number of education sessions have been provided including (but not limited to) preventing UTIs and the importance of hand hygiene. All infection control coordinators within The Selwyn Foundation meet annually to discuss and review the infection control programme.
<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 The Selwyn Foundation 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. Acute care needs support 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</p>

		activities to improve outcomes for residents.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Restraint is 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. There are two hospital residents with restraints (both with a chair brief restraint) and one hospital resident using an enabler (bedrail). Staff training is in place around restraint minimisation 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. A registered nurse is the restraint coordinator. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements.</p>
<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. Ongoing consultation with the resident and family/whānau are evident. Two hospital level residents' files where restraint was in use (chair brief restraint) 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</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. The use of restraint is linked to the residents' care plans. Internal restraint audits measure staff compliance in following restraint procedures. Monitoring is documented on a specific restraint monitoring form. 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>	<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 the registered nurse and staff/quality meetings. A review of resident files confirms 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>	<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/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 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p>	PA Low	<p>Complaints policy and procedures are in place and residents and their family/whānau have been provided with information on admission. A complaints folder has been maintained. There have been sixteen complaints received in 2016 and two made in 2017 year to date. Ten complaints evidenced follow-up letters, investigation and outcome resolutions.</p>	<p>Six of the sixteen complaints made in 2016 did not have any documented follow up, investigation or outcome resolutions.</p>	<p>Ensure that all complaints have documentation including follow-up letters, investigations and outcome resolutions within the required timeframes.</p> <p>90 days</p>
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	<p>The internal audit schedule for 2016 has been completed and 2017 is underway. Twelve internal audits that are not compliant, did not have corrective actions in place or were not signed off as completed.</p>	<p>Twelve out of thirty-two internal audits reviewed for 2016 and 2017 do not have documented evidence of corrective actions in place or have not been signed off as completed.</p>	<p>Ensure that all internal audits that are not compliant have corrective actions in place and are signed off as completed.</p> <p>90 days</p>

<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA Moderate</p>	<p>The pharmacist completes a weekly stocktake of controlled drugs delivered with the RNs. Fourteen of sixteen medication charts reviewed evidence prescribing that aligns with best practice. Twelve of sixteen medication signing charts reviewed evidence medication is administered as prescribed.</p>	<p>(i) Four of sixteen medication signing charts have signing gaps where medication is not documented as being administered as prescribed; (ii) Indication of use of 'as required' medication (Lorazepam) is not documented on two of sixteen medication charts.</p>	<p>(i) Ensure that medications are signed for at time of administration or reason for non-administration of prescribed medication is documented; (ii) Ensure that the GP documents the indication of use of 'as required' medication on the medication chart.</p> <p>60 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Moderate</p>	<p>Wound assessment, monitoring and wound management plans are in place for all wounds. Eight of ten wound management plans are current and have been updated with changes to wound management. Six of ten wounds document RN review within the specified timeframes. There are two wound care folders in place (one for RNs and one for care supervisors) who complete wound care in the two wings. This has contributed to confusion regarding current wounds being treated as there is duplication of three wound assessments and treatments plans for the same wound in each folder.</p>	<p>(i) Four of ten wounds do not evidence that the wounds had been reviewed in the prescribed timeframe; (ii) There are two wound care folders in place (one for RNs and one for care supervisors completing wound care), these evidence duplication of three wound assessments and wound management plans; (iii) Wound management plans for two chronic wounds reviewed do not clearly identify the current wound treatment plan.</p>	<p>(i) Ensure wounds are reviewed within the prescribed timeframes; (ii) Ensure that a system and process is implemented to reduce the duplication in wound care documentation and a more cohesive approach to wound management; (iii) Ensure that wound management plans are updated to reflect the current plan of treatment.</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
<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. 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>The results of the 2015 resident/relative surveys evidence that there was a need to improve and further develop the activity programme. A Selwyn Foundation diversional therapist was employed who has been instrumental in developing a new programme and supporting the activity teams in each facility (house).</p> <p>The residents are able to attend any activity in any of the facilities on-site, including those occurring in the retirement village. As each facility (house) has a different programme running, this means residents have more choice as to what and where they would like to attend. The care staff and activity teams transport the residents to the house activity they would like to attend.</p> <p>The service has introduced PARO, an advanced</p>

			<p>interactive therapeutic robot (seal) designed to stimulate interaction with residents with dementia, Alzheimer's and other cognition disorders. The 'touch of music' programme is a small laptop that is programmed with a selection of music the resident enjoys and can listen to via a headset. The staff report that for residents who are displaying signs of agitation or are unsettled, this can be a great distraction technique to use. Baby buddies is where young mums and their babies come and interact with residents. The residents report that this is one of their favourite activities, as they get to interact with the mums and babies and read or tell the children stories. Movies, art therapy, clown doctors, poetry performance, dance expression, cookery club and gardening are some of the other activities on offer. Residents have been growing their own vegetables, which are cooked and eaten by residents. One on one activities are provided and staff were observed spending one on one time with those residents who chose not to participate in group activities, or who are unwell.</p> <p>There is a designated van driver and residents are encouraged to get off the van and explore with the assistance of care staff and activity assistants. At weekends, the village van transports residents to events happening in the local community. Examples include theatre, concerts, art gallery and botanic gardens. Residents are encouraged to make suggestions and provide feedback on activities at resident meetings. Each house is allocated the use of the van for outings one day per week. As a result of recent suggestions, the residents went on a trip to Hobbiton to visit the Lord of the Rings fantasy village.</p> <p>The Kerridge monthly newsletter is available for</p>
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			<p>all staff, visitors, residents and families to read. The newsletter is written by a village resident.</p> <p>Residents and family members interviewed report enjoying the variety and diversity of the programme and the ability to attend activities of interest happening in their own house and at other houses. Residents meeting minutes and attendance sheets sighted evidenced significantly increased attendance at the activity programme in 2016.</p>
<p>Criterion 3.5.7</p> <p>Results of surveillance, conclusions, and 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>	CI	<p>When an infection occurs, an infection control report is completed and provided to the infection control coordinator. An acute care needs support care plan is also completed. The infection control coordinator keeps a monthly summary log of all infections and all are logged into the online database 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. The service has remained under the benchmark target range for urinary tract infections of 1.5 per 1000 bed nights since January 2016 to date.</p>	<p>In 2015, the infection control coordinator identified that while the infection rate was low compared to other facilities, a reduction in infection rates would benefit residents. The project was supported by the Selwyn clinical nurse specialist and the combined Selwyn infection control coordinators.</p> <p>All infections are comprehensively analysed for trends. Actions to reduce negative trends are identified and include staff and resident education, analysis of ideal products to be used and increased fluid rounds in hot weather. The actions are identified, discussed at staff/quality meetings and implemented as needed. A new monthly reporting form has been developed and these have been comprehensively completed. 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, Selwyn Kerridge House has remained under the benchmark target range for</p>

			urinary tract infections of 1.5 per 1000 bed nights since January 2016 to date.
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End of the report.