

# Selwyn Care Limited - Caswell House

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## 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:

<b>Legal entity:</b>	Selwyn Care Limited
<b>Premises audited:</b>	Caswell House
<b>Services audited:</b>	Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 27 March 2017 End date: 28 March 2017
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	46

# Executive summary of the audit

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## Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

### Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

## General overview of the audit

Selwyn Caswell House is owned and operated by the Selwyn Foundation and is one of four current services operating from the village site. The service provides care for up to 52 residents requiring rest home level care. On the day of the audit, there were 46 rest home 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.

A village manager oversees the group of aged care facilities on the site, including Selwyn Caswell House. The manager has been in the position for three years. Caswell House is managed by a care lead, who is a registered nurse (RN) and has been in the role since September 2014. She previously worked as a clinical coordinator at another Selwyn facility. The care lead is supported by a RN, who has worked at the Selwyn Foundation for over 20 years. Residents, relatives and the GP interviewed spoke positively about the service provided.

The service has exceeded the standard around good practice, infection control and activities.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		All standards applicable to this service fully attained with some standards exceeded.
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Policies and procedures are in place that adhere to 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 confirmed that residents and 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, which meets guidelines established by the Health and Disability Commissioner.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Services are planned, coordinated and are appropriate to the needs of the residents. A care lead and 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. Quality improvement plans are developed when service shortfalls 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. 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.		Standards applicable to this service fully attained.
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Residents are assessed prior to entry to the service. A baseline assessment is completed upon admission and an interRAI assessment is completed 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 service 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 comprehensive medication management policies that 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.
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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 and incidents are reported on in a timely manner. Staff receive 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. Laundry is completed in the centralised laundry off-site. Policies and procedures are in place for essential, emergency and security services, with adequate supplies should a disaster occur. There is always a staff member 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 receive 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. There were no enablers or restraints in use at the time of the audit. The registered nurse is the restraint coordinator.

## 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.

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is fully implemented. Documentation evidences that relevant infection control education is provided to all staff as part of their orientation and also as part of the ongoing in-service education programme. The 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)
<b>Standards</b>	1	44	0	0	0	0	0
<b>Criteria</b>	3	90	0	0	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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 around resident rights at orientation and as part of the annual in-service programme. Interviews with seven care staff (five caregivers, one registered nurse (RN) and one diversional therapist) confirmed their understanding of the Code. Six residents and five relatives 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>The service has policies and procedures relating to informed consent and advanced directives. All resident files reviewed include signed informed consent forms and advanced directive instructions. Staff are aware of advanced directives. Admission agreements were sighted which were signed by the resident or nominated representative. Discussion with residents and families identified that the service actively involves them in decision making.</p>

<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 confirm they are aware of their right to access independent advocacy services. Discussions with relatives confirms 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>
<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	<p>Residents and relatives interviewed confirmed 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>
<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>Complaints policy and procedures are implemented. Complaint forms are available at the service. Residents and family interviewed confirm 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 were aware of the complaints process and to whom they should direct complaints.</p> <p>A complaints folder is maintained. There were four complaints received in 2016 and three made in 2017 year to date. All of the complaints documentation includes follow-up letters, investigations and resolutions and had been completed within the required timeframes. Corrective actions have been implemented as needed.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>There is an information pack given to prospective residents and families, which 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 confirm that information is provided to them around the Code. Large print posters of the Code and advocacy information are displayed throughout the facility. The care lead or 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>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And</p>	FA	<p>A tour of the premises confirms there are areas that support personal</p>

<p>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>privacy for residents. Staff are respectful of residents' privacy and knock on doors prior to entering resident rooms. Staff are able to describe definitions around abuse and neglect that align with policy. 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. Caregivers described how choice is incorporated into resident care.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The Māori health plan policy for the organisation references local Māori healthcare providers regionally within New Zealand and provides recognition of Māori values and beliefs. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. The Selwyn Foundation works with their Tikanga partner through Te Pihopatanga O Te Taitokerau, which caters for all iwi. One resident living at the facility identifies as Māori. Māori cultural needs are addressed in the care plan.</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 or values are discussed and incorporated into the care plan. Six-monthly multidisciplinary team meetings occur to assess if needs are being met. Family/whānau are invited to attend. Discussions with relatives confirm that residents' values and beliefs are considered. Residents interviewed confirmed that staff take their values and beliefs into account.</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 confirms their awareness of professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p>	CI	<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. The service is proactive around implementing quality initiatives.</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. Fourteen incident/accident reports reviewed met this requirement. Relatives interviewed confirmed 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 were 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 Caswell 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 52 residents requiring rest home level care. On the day of the audit, there were 46 rest home residents. All residents are under the Aged Related Residential Care (ARRC).</p> <p>The aged care facilities on the site, including Selwyn Caswell House, are overseen by the village manager who has been in the position for three years. Caswell House is managed by a care lead, who is a registered nurse (RN) and has been in the role since September 2014. She previously worked as a clinical coordinator at another Selwyn facility. The care lead is supported by a RN, who has worked at the Selwyn Foundation for over 20 years. Both the care lead and RN are interRAI trained.</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'. The model underpins how the Selwyn Foundation provides services within the context of its mission. The strategic plan also includes the organisational goals and these are reflected in the 2016-2017 Selwyn Caswell business plan. The business plan describes the vision, values</p>

		and objectives of Selwyn Caswell 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 (sister facility on the same site) covers during the temporary absence of the care lead.
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>An established quality and risk management system is embedded into practice. Quality and risk performance is reported across facility meetings and to the group residential care manager. Discussions with the managers, 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.</p> <p>The quality monitoring programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation. There are clear guidelines and templates for reporting. The facility has implemented established processes to collect, analyse and evaluate data. This is utilised for service improvements. Key performance areas are benchmarked against other Selwyn facilities. Quality improvement plans (QIP's) are developed when service shortfalls are identified and these are monitored by group office. Results are communicated to staff at the monthly staff/quality meetings and reflect actions being implemented</p>

		<p>and signed off when completed.</p> <p>Health and safety policies are implemented and monitored by the Health and Safety Committee. The Selwyn Foundation Health and 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, mattress perimeter guards and identification and meeting of individual needs.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>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 14 incident/accident forms (a sample from February and 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 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>	FA	<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) included a robust and documented recruitment process and annual appraisals for staff. 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</p>

		to provide education sessions on required subjects. 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>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	A policy is in place for determining staffing levels and skills mix for safe service delivery. Rosters implement the staffing rationale. Caswell House roster identifies there is sufficient staffing cover for the safe provision of care for rest home residents. The care lead (RN) works full-time Monday to Friday and is available on call 24/7. She is supported by the RN and a senior care supervisor (caregiver) Monday to Sunday. Staff are visible, available and attend to call bells in a timely manner as confirmed by all resident and relatives interviewed. Staff interviewed stated that overall the staffing levels are satisfactory and that the managers provide good support. Residents and relatives interviewed report there are sufficient staff numbers. The Selwyn Foundation has its own bureau of nursing staff to cover sick leave and annual leave.
<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	The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded in their file within 24 hours of entry into the service. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access. Entries are legible, dated and signed by the relevant caregiver or nurse including designation. Individual resident files demonstrate service integration.
<p>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	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 contain all detail required under the Aged Residential Care Agreement. Family members and residents stated that they have received the information pack and have received sufficient information prior to and on entry to the service. Family members reported that the clinical lead is available to answer any questions regarding the admission process.

<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>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 ADHB "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 who 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 documented in progress notes.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The service has recently introduced an electronic medication management system into the rest home. 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 caregivers administer medicines. All staff who administer medicines are competent and have received medication management training. Fourteen individual resident's electronic medication charts were sighted. Resident medication charts are identified with photographs and allergies are recorded. All prescribed 'as required' medications document the indication for use. All medications were 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 was one resident self-administering medication on the day of audit. A competency to assess the residents continued ability to self-administer medication was sighted and was evidenced to be reviewed by the GP at the three-monthly medication review. The resident has a locked drawer in their room for safe storage of medication. Since the transition onto an electronic medication management system, standing orders are no longer in use.</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 an external contactor. A four-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 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, upon arrival and before service. The receiving kitchen also holds some sandwiches; biscuits, soup and fruit which is available to residents over a 24-hour period and supplies are replenished daily.</p> <p>There is evidence of modified diets being provided (e.g., diabetic menu) 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.</p> <p>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. 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 a 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 advised to contact Older Persons Health.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are</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-</p>

gathered and recorded in a timely manner.		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>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 long-term care plans 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 that allied health care professionals are 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 developed following a change in health. Interventions documented are sufficiently detailed to address the desired outcome/goal. Integration of records and monitoring documents are well managed.</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>	FA	<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 (e.g., to the district nurse or wound care specialist nurse). If external medical advice is required, this will be actioned by the GPs. Staff have access to sufficient medical supplies (e.g., 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 were completed for all wounds. On the day of audit there were seven wounds. These included one surgical wound, one skin tear, one haematoma, one skin cancer lesion and three pressure injuries (one unstageable and two healing stage II). All wounds have been reviewed in appropriate timeframes. All wounds evidence progress towards healing with the exception of the unstageable pressure injury. Wound</p>

		<p>nurse specialist and GP input was evidenced for all pressure injuries.</p> <p>Interviews with registered nurses and caregivers demonstrates 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><b>Standard 1.3.7: Planned Activities</b></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 (qualified diversional therapist) and assistants at Selwyn Caswell House deliver the programme. The programme runs over seven days per week. The Selwyn Foundation's diversional therapist assists with the programming and also mentors and supports all activity coordinators and assistants. A wide range of activities addressing the abilities and needs of residents in the rest home 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 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 resident's condition determine) as part of the care plan evaluation/review.</p> <p>Residents and family interviewed confirm they enjoy the variety of activities and 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><b>Standard 1.3.8: Evaluation</b></p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Care plans reviewed have been evaluated by registered nurses six-monthly, or when changes to care occurred. Acute care needs support care plans for short-term needs have been evaluated and either resolved or added to the long-term care plan as an ongoing need. The</p>

		<p>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 interviewed 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 the resident had been reassessed for a higher or different level of care. Discussion with the care 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 Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>The service has documented policies and procedures for the safe and appropriate storage and disposal of waste and hazardous substances. Waste is appropriately managed.</p> <p>Chemicals 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 in place 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>	FA	<p>The building holds a current warrant of fitness, which expires 28 May 2017. The Selwyn Foundation employs a full-time property manager and three maintenance staff. 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 29 November 2016. Medical equipment requiring servicing and calibration was last conducted on 2 February 2017. 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</p>

		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>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>	FA	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 evidence that corrective actions have been implemented and evaluated when temperatures were evidenced to be above the target range. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning.
<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>	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.
<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	There is a large lounge/dining area. There are several other lounge areas including a sun room 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.
<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	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's policies and procedures. Cleaning staff have completed chemical safety training.
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during</p>	FA	There is an emergency response and civil defence plan to guide staff in managing emergencies and disasters. Emergency response and first

<p>emergency and security situations.</p>		<p>aid is included in the mandatory in-service training programme. There is a first aid trained staff member on every shift. Staff records sampled evidences current training regarding fire, emergency and security education. There is a letter from New Zealand Fire Service reviewed, dated 1 November 1999, advising approval of fire evacuation schemes. The last trial evacuation was held on 14 October 2016 and has been held six-monthly.</p> <p>Information in relation to emergency and security situations is readily available for service providers and residents. There are two fully stocked civil defence kits. There is a gas barbeque should the mains gas supply fail. The service has adequate stored water including water tanks for an emergency. There is an appropriate call bell system that is easily used by the residents or staff to summon assistance if required. Call bells are accessible and are available in resident areas including bedrooms, ensuites, the lounge and dining room.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>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>	<p>FA</p>	<p>Selwyn Caswell 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.</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>	<p>FA</p>	<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 IC team (comprising all staff) have good external support from the local laboratory, infection control team and IC nurse specialist at the DHB. The infection control</p>

		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><b>Standard 3.3: Policies and procedures</b></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. The policy defines roles, responsibilities and oversight, the infection control team, training and education of staff and scope of the programme.
<p><b>Standard 3.4: Education</b></p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>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.</p> <p>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.</p> <p>A number of education sessions have been provided including (but not limited to) preventing urinary tract infections and the importance of hand hygiene.</p> <p>All infection control coordinators within The Selwyn Foundation meet annually to discuss and review the infection control programme.</p>
<p><b>Standard 3.5: Surveillance</b></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	Infection surveillance is an integral part of the infection control programme and is described in The Selwyn Foundations 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. 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

		<p>quality/staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible. There have been no outbreaks since the previous audit.</p> <p>The service has exceeded the standard around the use of surveillance activities to improve outcomes for residents.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There are restraint policies and procedures that include definition of restraint and enablers that are congruent with the definition in NZS 8134.0. The RN is the restraint coordinator. There are no enablers or restraints in use. Staff receive training in restraint and enablers on orientation and is ongoing. The Selwyn Foundation restraint coordinators meet annually, which includes training. Enablers/restraint are discussed at the monthly staff/quality meetings.</p>

## Specific results for criterion where corrective actions are required

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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.

No data to display
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## Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>The service is proactive around implementing quality initiatives. A number of improvements have been made including (but not limited to); (i) introducing clown doctors – reducing isolation and loneliness among residents due to physical limitations or self isolation. (ii) Business Communication Course was completed– improving staff confidence and morale. (iii) Improved overall care planning and reviews due to improved reporting with the integration from interRAI. (iv) Implemented a post-death procedure, which included implementing lighting of a candle, condolence book, deceased’s departure from the building from the main entrance and a condolence card with messages from the condolence book being sent to the NOK. This has received favourable feedback</p>	<p>A quality initiative was implemented around advanced care planning (ACP). Of the residents residing in Caswell at the beginning of this year only 28 were mentally capable of completing an ACP. Of those 28, only 2 had an advanced care plan in place. The RN was encouraged and completed her Level 1 ACP training. The ACP co-ordinator was contacted and gave a talk to the residents about the benefits of completing an ACP. Each resident that was mentally capable of completing an ACP was spoken with about the ACP by the RN upon their care review coming due. Most of these residents were happy to complete an ACP as they felt that their wishes and needs concerning their health and end of life wishes would be made known and respected. From February 2017 until the time of the audit a further 10 of the 36 residents had completed an</p>

		from the residents, staff and families.	ACP to go in their file and also to be sent to the ADHB. This amounts to a nearly 50% uptake of the mentally competent residents residing at Caswell having an ACP. The residents who have completed an ACP feel happy in the knowledge that their wishes regarding their health and end of life care are known and documented both with Caswell and with the ADHB, and that their families are aware of this and will not feel burdened with having to make those decisions when the time arises.
<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 evidenced that there was a need to improve and further develop the activity programme. A Selwyn Foundation diversional therapist was employed and 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'd like to attend.</p> <p>The service has introduced PARO, an advanced interactive therapeutic robot (Seal) designed to stimulate patients with dementia, Alzheimer's and other cognition disorders. Residents are encouraged to make suggestions and provide feedback on activities at monthly resident meetings. Each house is allocated the use of the van for outings one day per week.</p> <p>As a result of recent suggestions, the residents</p>

			<p>went on a trip to Hobbiton to visit the Lord of the Rings fantasy village. There is a designated van driver and residents are encouraged to get off the bus and explore with the assistance of care staff and activity assistants.</p> <p>Residents in the rest home have been growing their own vegetables, which are cooked and eaten by residents. Other activities include: musical entertainment, spontaneous Devonshire teas, BBQs, cognitive therapy activities, body percussion, art therapy, clown doctors, poetry and drama, movies, cookery club and gardening. On the days of audit, residents and visitors were observed during pet therapy, where each resident got an opportunity to cuddle a baby rabbit.</p> <p>At weekends, the village van transports residents to events happening in the local community.</p> <p>Residents and family members interviewed reported 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 sighted evidenced significantly increased attendance at the activity programme in 2016.</p>
<p>Criterion 3.5.7 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>	<p>CI</p>	<p>When an infection occurs (based on research based standardised definitions), 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 maintains 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</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 were comprehensively analysed for trends. Actions to reduce negative trends were identified and included staff and resident</p>

		<p>taken, trends identified, 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>education, analysis of ideal products to be used and increased fluid rounds in hot weather. The actions were identified, discussed at staff/quality meetings and implemented. A new monthly reporting form was 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 implemented for each sub-group. The summary section includes details behind the analysis of improvements previously implemented.</p> <p>As a result of this detailed analysis and addressing of trends, Selwyn Caswell House has remained under the benchmark target range for urinary tract infections of 1.5 per 1000 bed nights since January 2016 to date.</p>
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End of the report.