# Selwyn Care Limited - Selwyn Park

## 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Selwyn Care Limited

**Premises audited:** Selwyn Park

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

**Dates of audit:** Start date: 10 April 2017 End date: 11 April 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:** 88

# 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 |
|  | 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 Park is owned and operated by the Selwyn Foundation and cares for up to 88 residents requiring rest home, hospital or dementia level care. On the day of the audit, there were 88 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 service is managed by a manager who has both management and aged care experience. The care centre is overseen by the care manager and assistant care lead, both registered nurses (RNs) with experience in aged care. They are supported by the group residential care manager. Residents, relatives and the GP interviewed spoke positively about the service provided.

The service has exceeded the standard around infection control surveillance. This audit has identified areas for improvement around an aspect of care planning and the completion of neurological observations following unwitnessed falls.

## Consumer rights

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Standards applicable to this service fully attained. |

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. There is an established Māori health plan in place. Individual care plans reference the cultural needs of residents. Discussions with residents and relatives confirm 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. Examples of good practice were provided.

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

## Organisational management

|  |  |  |
| --- | --- | --- |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

Services are planned, coordinated and are appropriate to the needs of the residents. The village manager is 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 in place. 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.

Registered nursing cover is provided twenty-four hours a day, seven days a week. Residents and families report that staffing levels are adequate to meet the needs of the residents. The integrated residents’ files are appropriate to the service type.

## Continuum of service delivery

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of low risk. |

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 support plans.

Assessment tools and monitoring forms are used to assess the level of risk and ongoing support required for residents. Long-term 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. The food service is provided by an external catering company and cooked on-site. 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. 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 to evaluate the effectiveness of these services. Laundry is undertaken on-site. Policies and procedures are in place for essential, emergency and security services, with adequate supplies should a disaster occur. There are 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 education and 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. Two residents were using restraints and no residents were using enablers at the time of audit.

## 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 implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and 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.

## 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** | 0 | 48 | 0 | 1 | 1 | 0 | 0 |
| **Criteria** | 1 | 98 | 0 | 1 | 1 | 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | The Selwyn Foundation policies and procedures are being implemented that align with the requirements of the Code of Health and Disability Services Consumers’ Rights (the Code). Families and residents are provided with information on admission, which includes information about the Code. Staff receive training around resident rights at orientation and as part of the six-monthly mandatory training/education programme. Interviews with care staff (five caregivers, four registered nurses (RNs) and two activity coordinators) confirmed their understanding of the Code. Eight residents (five rest home level and three hospital level) and eight relatives (two hospital level, three rest home level and three dementia) interviewed confirmed that staff respect privacy and support residents in making choices. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | The service has policies and procedures relating to informed consent and advanced directives. All ten resident files reviewed included signed informed consent forms and advanced directive instructions. Staff are aware of advanced directives. For those residents who are not mentally competent to make a decision regarding resuscitation and no previous resuscitation instructions are in place, there is evidence of GP discussion with family and a medical decision regarding resuscitation status is documented by the GP. Enduring power of attorney evidence is sought prior to admission and activation documentation is obtained and both are filed with the admission agreements. Where legal processes are ongoing to gain EPOA, this is recorded, as are letters of request to families for the supporting documentation. Admission agreements are in place for all residents, all are signed by the resident or nominated representative. Discussion with residents and families identifies that the service actively involves them in decision making. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Residents interviewed confirm they are aware of their right to access independent advocacy services. Discussions with relatives confirms that the service provides opportunities for the family/EPOA to be involved in decisions. The chaplain is identified by staff and residents as an advocate. The resident files include information on residents’ family/whānau and chosen social networks. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | Residents and relatives interviewed confirm open visiting. Visitors were observed coming and going during the audit. The activities programme includes opportunities to attend events outside of the facility. Residents are supported and encouraged to remain involved in the community. Relatives and friends are encouraged to be involved with the service and care. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The service has a complaints policy that describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission. Interviews with residents and relatives confirms their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints.  A complaint register includes written and verbal complaints, dates and actions taken. A total of seventeen complaints were received from January 2016 to present date. The service noted a trend around food service. A quality improvement plan has been developed, implemented and is currently being evaluated.  Complaints are being managed in a timely manner, meeting requirements determined by the Health and Disability Commissioner (HDC). There is evidence of lodged complaints being discussed in management and staff meetings. All complaints received have been documented as resolved with appropriate corrective actions implemented. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | There is an information pack given to prospective residents and families that includes information about the Code and the Nationwide Advocacy Service. There is the opportunity to discuss aspects of the Code during the admission process. Residents and relatives interviewed confirmed that information had been provided to them around the Code. Large print posters of the Code and advocacy information are displayed throughout the facility. A manager discusses the information pack with residents/relatives on admission. Families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | A tour of the premises confirmed there are areas that support personal privacy for residents. Staff were observed to be respectful of residents’ privacy by knocking on doors prior to entering resident rooms. Staff can describe definitions around abuse and neglect that aligned with policy. Residents and relatives interviewed confirm that staff demonstrate sensitivity in regard to resident privacy and dignity and where possible, encourage the resident to be involved in their care according to their ability.  The service has a philosophy that promotes quality of life and involves residents in decisions about their care. Resident preferences are identified during the admission and care planning process and this includes family involvement. Interviews with residents confirmed their values and beliefs were considered. Interviews with caregivers described how choice is incorporated into resident cares. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  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. | FA | The Māori health plan policy for the organisation references local Māori healthcare providers regionally within New Zealand and provides recognition of Māori values and beliefs. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with disability and other community representative groups as requested by the resident/family. Cultural needs are addressed in the care plan. Two residents who identify as Māori confirm their cultural needs are being met by the service. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | An initial care planning meeting is carried out and the resident and/or whānau as appropriate are invited to be involved. Individual beliefs or values are discussed and incorporated into the care plan. Six-monthly multidisciplinary team meetings occur to assess if needs are being met. Family are invited to attend. Discussions with relatives confirms that residents’ values and beliefs are considered. Residents interviewed confirm that staff take into account their values and beliefs. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Staff job descriptions include responsibilities. The monthly full facility meetings include discussions around professional boundaries and concerns as they arise. Management provided guidelines and examples of mentoring for specific situations. Interviews with the managers and care staff confirm their awareness of professional boundaries. Caregivers are trained to provide a supportive relationship based on sense of trust, security and self-esteem. Two caregivers from the dementia unit described how they build a supportive relationship with each resident. Interviews with three families from the dementia unit confirmed the staff assist to relieve resident’s anxiety. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | Evidence-based practice is evident, promoting and encouraging good practice. Registered nursing staff are available 7 days a week, 24 hours a day. A house GP visits the facility two days a week and provides an after-hours service. The general practitioner (GP) reviews residents identified as stable every three months, with more frequent visits for those residents whose condition is not deemed stable. The GP interviewed is satisfied with the level of care that is being provided.  The service receives support from the district health board, which includes nurse specialist’s visits. Physiotherapy services are provided on-site four hours per week. A dietitian is also available for urgent consultations. A podiatrist is on-site every six weeks. There is a regular in-service education and training programme for staff. The service has links with the local community and encourages residents to remain independent.  Selwyn Park is benchmarked against other villages within The Selwyn Foundation. If the results are above the benchmark, a quality improvement plan is developed by the service.  The service demonstrated a number of examples of good practice including: participating in an ongoing pilot study with the dental association around improving oral health in the elderly and reducing oral infections; participating in a study on hand hygiene for a Masters in Nursing study; participating in clinical trials of new wound care products and trials regarding the medical management of residents with recurrent UTIs (CI link to 3.5.7). Success of the participation in oral hygiene, hand hygiene and wound dressing trials has not yet been evaluated as it is too early in the process to gain any meaningful data. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There is an accident/incident reporting policy to guide staff in their responsibility around open disclosure. Staff are required to record family notification when entering an incident into the system. All 30 incident reports reviewed for March- April 2017 met this requirement. Family members 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. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Selwyn Park is part of The Selwyn Foundation Group. The facility is certified to provide rest home and hospital (geriatric and medical) and dementia level care for up to 88 residents. Forty-six beds are dedicated to rest home level of care, twenty-seven to hospital and fifteen to dementia. The facility was fully occupied at the time of audit.  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 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 Park business plan, which describes the vision, values and objectives of Selwyn Park. Annual goals are linked to the business plan and reflect regular reviews via regular meetings.  Selwyn Park is currently managed by an experienced village manager/enrolled nurse who has been in the role since June 2015. She is supported by a care manager /registered nurse (RN), who has been in the role for two years and has previous experience as a nurse manager and clinical tutor. There is also an assistant care lead/RN who has been in his role at the facility for two years and has been with The Selwyn Foundation for eight years.  They are supported by the group residential care manager.  The village manager, care manager and assistant care lead have maintained at least eight hours of professional development activities related to managing an aged care facility. |
| Standard 1.2.2: Service Management  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. | FA | The care manager and assistant care lead cover during the temporary absence of the village manager. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | An established quality and risk management system is embedded into practice. Quality and risk performance is reported across facility meetings and to the group residential care manager. Discussions with the managers (group residential care manager, village manager, care manager and assistant care lead), the GP and staff reflects staff involvement in quality and risk management processes.  Resident meetings are monthly. 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 Selwyn Park. Following feedback from the survey, quality improvements have been implemented around communication with family/residents and the activity programme.  The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. The service's policies are reviewed at a national level by the Clinical Governance Group with input from facility staff every two years. Clinical guidelines are in place to assist care staff. Updates to policies included procedures around the implementation of interRAI.  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 and signed off when completed.  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. Health and safety meetings are conducted two-monthly at Selwyn Park.  Falls prevention strategies are in place including (but not limited to): individual and group exercise programme; meeting individual toileting needs; sensor mats; use of perimeter guard mattresses; increased monitoring; identification and meeting of individual needs. |
| Standard 1.2.4: Adverse Event Reporting  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. | PA Moderate | 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 30 incident/accident forms (a sample from March and April 2017) identifies that forms are fully completed and include follow up by a registered nurse. However, neurological observations were not evidenced to be consistently completed for unwitnessed falls as per policy. The village manager, care manager and assistant care lead are involved in the adverse event process. There is a debriefing process for all critical incidents that includes a staff debrief and a review of the incident at the Clinical Governance Group.  The group residential care manager was able to identify situations that would be reported to statutory authorities including (but not limited to): infectious diseases, pressure injuries, serious accidents and unexpected death. Appropriate notification has been made as needed.  The service has undertaken a review of falls involving fractures. All three demonstrated that there are no trends such as staffing levels, times of day, certain areas of the facility or similar. This process demonstrates that all had a full critical event procedure followed. A suspected gastro outbreak in September 2016 was notified appropriately and laboratory results from samples taken did not confirm any infectious outbreak had occurred. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | There are comprehensive human resources policies in place. Ten staff files reviewed (the care manager, the assistant care lead, two registered nurses, a housekeeper, laundry assistant, the diversional therapist and three caregivers) included a comprehensive recruitment process including: reference checking, signed employment contracts and job descriptions, completed orientation programmes and annual performance appraisals. One staff member who had been recently employed was completing an orientation and an annual appraisal was not required.  A register of registered nursing staff and other health practitioner practising certificates is maintained.  The orientation programme provides new staff with relevant information for safe work practice. There is an implemented annual education and training plan that exceeds eight hours annually. The training plan is implemented using a ‘train the trainer’ model, where key staff are trained to provide education sessions on subjects that cover a number of required trainings. Aspects of training are provided during full-day training sessions. If staff do not attend the scheduled mandatory education day, the educator completes a one-on-one education session with the absentee(s) within one month of the training date. Incidental training is provided according to identified need and at staff request. There is an attendance register for each training session and an individual staff member record of training.  There are sixteen staff who regularly work in the dementia unit. Fourteen staff have completed the required NZQA dementia education modules and two staff who have been employed in the last three months, are enrolled on the Careerforce programme.  Registered nurses are supported to maintain their professional competency. Six of eight permanent registered nurses have completed their interRAI training. There are implemented competencies for registered nurses. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | A policy is in place for determining staffing levels and skills mix for safe service delivery.  In the hospital wing, a registered nurse is on duty 24/7. In the rest home wing, a registered nurse is on duty four mornings per week Mon-Thursday and seven afternoons per week. A care supervisor (senior caregiver) is on duty in the rest home Friday to Sunday morning. In the dementia wing, an RN works three mornings per week Thursday- Saturday. The RN in the rest home on afternoons, provides support to the care supervisor on duty in the dementia unit.  There is a caregiver on duty in both the dementia and rest home wings at night. In the hospital wing, there are two caregivers and an RN on duty at night.  There are sufficient caregivers rostered on duty each day to support the registered nurses and meet the needs of residents.  Staff were visible and were attending to call bells in a timely manner as confirmed by all residents interviewed. Staff interviewed stated that overall the staffing levels are satisfactory and that the managers provide good support. Residents and family members interviewed report there are sufficient staff numbers. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access. Entries are legible, dated and signed by the relevant caregiver or nurse including designation. Individual resident files demonstrate service integration. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | 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 interviewed state that they have received the information pack and have received sufficient information prior to and on entry to the service. Specific information about the dementia unit is provided to families. Family members report that the care manager or 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 DHB ‘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. |
| 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. | FA | Twenty medication files were sampled (ten rest home, six hospital and four dementia level of care). The medication management policies comply with medication legislation and guidelines. All required medication checks have been completed. Resident’s medicines are appropriately and securely stored in accordance with relevant guidelines and legislation. Medication fridge temperature checks are conducted and recorded.  Medication administration practice complies with the medication management policy for the medication rounds sighted. Registered nurses and caregivers administer medicines. All staff administering medicines are competent and have received medication management training. The facility uses a robotically packed medication management system for the packaging of all tablets. Two RNs reconcile the delivery of new medication and document this. There is evidence of three-monthly reviews by the GP.  There are two rest home residents who self-administer some medicines. Both residents self-administering their own medication have completed the required competency assessments. Medicines standing orders are in use, are reviewed annually and comply with current guidelines and legislation. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The food service is contracted to an external catering company who use the facility kitchen to prepare and cook meals. The service has a kitchen manual. An eight-weekly seasonal menu is implemented. A dietitian has reviewed and approved the menu. All residents have a dietary requirements chart completed on admission.  The cook receives a copy of each resident’s dietary requirements that include likes/dislikes and the cook visits residents to seek feedback. A quality improvement plan is currently being implemented to address some issues identified though the complaints process regarding the food service.  Alternatives food choices are offered and provided as needed. There is evidence of modified diets being provided (eg, diabetic menu) and further nutritional supplements. There is extra food available for dementia residents, confirmed at staff interviews. Extra snacks (eg, fruit, sandwiches, biscuits and puddings) were sighted in the dementia unit.  Residents and relatives interviewed confirm likes/dislikes are accommodated and advised that the food service has improved over the last three months. Fridge and freezer temperatures are recorded daily. Perishable foods in the refrigerators are date-labelled and stored correctly. The kitchen is clean and has a good workflow. Chemicals are stored safely and safety datasheets are available. Personal protective equipment is readily available and staff were observed to be wearing hats, aprons and gloves. All kitchen staff have received appropriate food safety training. |
| Standard 1.3.2: Declining Referral/Entry To Services  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. | FA | There is policy in place regarding the process for declining entry. Consumers are declined entry when there are no beds available. 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. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Initial interRAI assessments and reviews are evident in printed format in all resident files. Resident files reviewed identify that risk assessments are 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. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Low | 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 that 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. Not all long-term care plans sampled have been reviewed and updated in a timely manner following a change in need. Integration of records and monitoring documents are well managed. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | 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 GPs. Staff have 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.  Wound assessment, treatment and wound management plans are completed for all wounds. On the day of audit there were thirteen wounds. These included: two surgical wounds, one pressure injury (recently healed stage II), one graze, one chronic sinus, seven skin tears and one infected ingrown toenail. All wounds have been reviewed in appropriate timeframes. All wounds evidence progress towards healing with the exception of the chronic sinus wound. Wound nurse specialist and GP input is evidenced for the now healed pressure injury. Selwyn Park are trialling new wound assessment, management and treatment plan documentation and providing feedback to The Selwyn Foundation Clinical Governance Team.  Interviews with registered nurses and caregivers demonstrated an understanding of the individualised needs of residents. Monitoring charts sighted included behaviour charts, turning charts, food and fluid charts, regular monitoring of bowels and regular (monthly or more frequently if required) weight management. |
| Standard 1.3.7: Planned Activities  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. | FA | A review of the activity programme confirms that independence is encouraged and choices are offered to residents. The activity coordinator (qualified diversional therapist) and two activity assistants at Selwyn Park deliver the programme. The programme runs over seven days per week. The Selwyn Foundation’s diversional therapist, based in Auckland, assists with the programming and also mentors and supports all activity coordinators and assistants. A wide range of activities which support the abilities and needs of residents in the facility are provided.  Activities included physical, mental, spiritual and social aspects of life to improve and maintain residents’ wellbeing.  On admission, an activity coordinator completes an assessment for each resident and an activity plan is completed. A record is kept of individual resident’s activities and progress notes are completed monthly. Reviews are conducted six-monthly (or earlier should the residents condition determine) as part of the care plan evaluation/review. In the dementia files reviewed, residents have an activity plan that document activities that can be utilised to de-escalate challenging behaviours, which are specific to individual residents.  Residents and family interviews confirm they enjoy the variety of activities and are very satisfied with the activities programme. Activities include outings as well as community involvement.  A monthly meeting is held where residents and relatives have input. Minutes are recorded at the meeting and quality improvements identified and feedback given. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Care plans reviewed have been evaluated by a registered nurse six-monthly. Care plans are evaluated to record progress towards achievement of the desired goals. Acute care needs support care plans for short-term needs are evaluated as needed. 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 interviewed confirm they are invited to attend the care plan reviews and GP visits. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | 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 assistant 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 assistant clinical lead and registered nurses identifies that the service has access to a wide range of support either through the GP, The Selwyn Foundation’s own specialists, Mental Health Services, psychogeriatrician and hospice staff. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | There are policies and procedures in place for the storage and use of chemicals. Safety data sheets are available for staff. There is a chemicals spills kit readily accessible. There have been no incidents regarding chemical spillage or accidents. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances. There are policies and procedures in place for the management of waste. Three sluice rooms are available for the disposal of waste and hazardous substances. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building holds a current warrant of fitness, which expires on 1 July 2017.  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 space to meet their needs. External areas are safe and well maintained. There is a secure external garden area in the dementia unit which residents were observed using during the audit. The facility has a van available for transportation of residents. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  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. | FA | All but two rooms in the hospital bedrooms have ensuites. The communal toilets and bathroom are in close proximity to those two bedrooms. Four rest home bedrooms have ensuites. The dementia unit rooms have hand basins. Handrails are appropriately placed in ensuite bathrooms and communal showers and toilets. Privacy is assured with the use of ensuites. Communal toilet/shower/bathing facilities have a system that indicates if it is engaged or vacant. Fixtures, fittings, floorings and wall coverings are good condition and are made from materials which allow for ease of cleaning. Hot water temperatures are monitored monthly and are within safe range as per current guidelines and legislation. |
| 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 | Bedrooms in all the units are spacious and of an adequate size appropriate to the level of care provided. The rest home rooms allow for the resident to move about the room independently with the use of mobility aids. The hospital level rooms allow for the easy manoeuvre of hoists, lazy boy chairs and other equipment required to safely deliver care. The bedrooms in the dementia units have sufficient space for residents to move about safely with mobility aids if required. Residents and their families are encouraged to personalise the bedrooms. |
| 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 | Residents have access to lounges, dining rooms and other communal areas throughout the facility. Residents interviewed confirm there are areas available to them if they want to sit quietly or entertain others or if they don’t want to participate in activities offered. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely. Residents in the dementia unit were observed to freely mobilise inside the unit and in the secure external garden area. There are low stimulus areas in the dementia unit. All the corridors are wide with appropriately placed handrails. Residents interviewed state that they are happy with the dining and lounge facilities. |
| 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 | Dedicated cleaning staff are rostered on to clean the facility. They have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme. Residents interviewed are satisfied with the standard of cleanliness in the facility.  Dedicated laundry staff complete all laundry on-site in an appropriately appointed laundry. Residents interviewed are satisfied with the laundry service. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | There is at least one staff member on duty at all times with a current first aid certificate. There are sufficient first aid and dressing supplies available. Emergency preparedness plans are accessible to staff and include management of all potential emergency situations. The service has implemented policies and procedures for civil defence and other emergencies. The service has civil defence resources and supplies. The service has an approved fire evacuation scheme. Fire evacuation training and drills are conducted six-monthly.  Call bells were situated in all communal areas, toilets, bathrooms and personal bedrooms. Residents were sighted to have call bells within reach during the audit. Where appropriate sensor mats were also observed to be in use. The service has a visitor’s book at reception for all visitors including contractors to sign in and out. Appropriate security systems are in place. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | General living areas and all resident rooms are appropriately heated and ventilated. All rooms have external windows that open allowing plenty of natural sunlight. |
| Standard 3.1: Infection control management  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. | FA | Selwyn Park 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 key performance indicators. A registered nurse is the designated infection control nurse with support from the assistant care lead and the infection control team. Minutes are available for staff. Audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | A registered nurse at Selwyn Park is the designated infection control (IC) nurse. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse and IC team have good external support from the local laboratory infection control team and IC nurse specialist at the DHB. The infection control team is representative of the facility. Infection prevention and control is included as part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available. |
| Standard 3.3: Policies and procedures  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. | FA | There are Selwyn Foundation infection control policies and procedures appropriate for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies were developed by the Selwyn clinical governance and have been reviewed and updated. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred. The infection control nurse has completed infection control training through the Selwyn infection control coordinators bi-annual meeting/training days. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Infection surveillance is an integral part of the infection control programme and is described in Selwyn’s infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. Short-term care plans are used. Surveillance of all infections is entered on to a monthly infection summary. This data is monitored and evaluated monthly and annually and provided to Selwyn head office for benchmarking. Infections are part of the key performance indicators. Outcomes and actions are discussed at quality/staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible. A suspected gastro outbreak in September 2016 was appropriately managed. The facility has exceeded the standard around the management of residents with recurrent urinary tract Infections (UTIs) and the reduction of UTIs at Selwyn Park over the last twelve months. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. Restraint minimisation policies and procedures are comprehensive and include definitions, processes and use of restraints and enablers.  There were no residents using enablers and two hospital residents with restraints (bedrails) during the audit.  Staff training is in place around restraint minimisation and enablers, falls prevention and management of challenging behaviours. |
| Standard 2.2.1: Restraint approval and processes  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. | FA | The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator (a registered nurse) and for staff are documented and understood. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | 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 restraints are in use (bedrails), were selected for review. The completed assessment considered those listed in 2.2.2.1 (a) - (h). |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | 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.  Restraint authorisation is in consultation/partnership with the resident, family and the GP. The use of restraint is linked to the residents’ care plans. Internal restraint audits measure staff compliance in following restraint procedures. Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Monitoring was evidenced to be consistently documented on the two restraint monitoring records reviewed.  A restraint register is in place providing an auditable record of restraint use and is completed for all residents requiring restraints and enablers. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | 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 registered nurse, full facility and quality management meetings. A review of two resident files identifies that evaluations are up to date. The service provided evidence where evaluation of the need for the use of restraint was evaluated and removal of a restraint was trialled successfully for one resident. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | The restraint minimisation programme is discussed and reviewed at the annual organisation-wide restraint coordinators meetings, monthly registered nurse meetings, monthly full facility and quality management meetings. Meeting minutes include (but are not limited to): a review of the residents using restraints or enablers, updates (if any) to the restraint programme and staff education and training. |

# 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)** |
| Criterion 1.2.4.3  The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk. | PA Moderate | Individual incident reports are completed for each incident/accident with immediate action noted. The data is linked to the organisation's benchmarking programme and this is used for comparative purposes. Minutes of the staff meetings reflect a discussion of results. Three of eight incident reports for unwitnessed falls evidenced that neurological observations had been fully completed as per policy. | Five of eight incident forms were sampled where the resident had experienced an unwitnessed fall. RN assessment was documented following the incident however, neurological observations were not completed as per policy. | Ensure that neurological observations are recorded for unwitnessed falls as per policy.  60 days |
| Criterion 1.3.5.2  Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Low | All resident files reviewed but one, had in-depth care plans that address assessed needs. However, one hospital care plan reviewed had not been updated when a change in resident need had occurred. | One care plan for a hospital resident with a pressure injury had not been updated to reflect the pressure injury management interventions currently being implemented (link to tracer 1.3.3.1). | Ensure care plans are updated when there are changes to resident needs.  60 days |

# Specific results for criterion where a continuous improvement has been recorded

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

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

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

|  |  |  |  |
| --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 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. | CI | Individual infection reports are completed and any trends identified are discussed at the clinical and infection control meetings. Key performance indicator data (KPIs) are reviewed and a quality improvement plan is developed for any trends identified and communicated to staff. | The village has remained below the target benchmark rate of 1.5 per 1000 bed nights for urinary tract infections since January 2016. The service was part of a pilot study around the medical management of residents known to have recurrent urinary tract infections. Six residents were involved in the trial of prescribed medication and recent evidence supports that the trial was successful. All six residents evidenced a reduction in UTIs over a twelve-month period. Two residents experienced no infections during this period, evidencing a significant reduction from seven each from the previous twelve months. The other four residents evidenced a reduction of 67-88% during the same period. |

End of the report.