

# Selwyn Care Limited - Brian Wells Lodge

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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:

**Legal entity:** Selwyn Care Limited

**Premises audited:** Brian Wells Lodge

**Services audited:** Dementia care

**Dates of audit:** Start date: 9 April 2014 End date: 9 April 2014

**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:** 14

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

## General overview of the audit

Brian Wells is owned and operated by the Selwyn Foundation and provides care for up to 16 residents requiring rest home (dementia) level care. On the day of the audit there were 14 residents. The assistant village manager and assistant care lead are well qualified and experienced for the roles. Relatives and the general practitioner (GP) interviewed spoke positively about the service provided.

The 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 relatives, staff and management.

This audit has identified no areas for improvement. The standard has been exceeded around quality and risk management processes, incident management and staff training.

## 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.	Green	Standards applicable to this service fully attained.
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The staff at Brian Wells ensures that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and services is easily accessible to residents and families. Information on informed consent is included in the admission agreement and discussed with residents (where able) and relatives. Informed consent processes are followed and residents' clinical files reviewed evidence informed consent and advanced directives are documented. Complaints and concerns have been managed and a complaints register is maintained.

## 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.		All standards applicable to this service fully attained with some standards exceeded.
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Brian Wells has a quality and risk management system in place that is implemented and monitored, which generates improvements in practice and service delivery. Key components of the quality management system link to relevant facility meetings. The service is active in analysing data with recent evidence of benchmarking outcomes with other similar aged care facilities. Corrective actions are identified and implemented. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and appropriately managed. There is a comprehensive orientation programme that provides new staff with relevant and specific information for safe work practice. The in-service education programme covers relevant aspects of care and support. The staffing levels provide sufficient and appropriate coverage for the effective delivery of care and support. Staffing is based on the occupancy and acuity 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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The service has a documented assessment process and resident's needs are assessed prior to entry. There is an information pack available for residents/families/whānau at entry that includes information specific to dementia care.

Assessments, care plans and evaluations are completed by the registered nurse. Residents (as appropriate), relatives/whanau were involved in planning and evaluating care. Service delivery plans demonstrate service integration and are individualised to meet the resident's needs. Care plans are evaluated six monthly or more frequently when clinically indicated. Acute care plans are available for use for short term needs. The service facilitates access to other medical and non-medical services.

The on-site diversional therapist oversees the seven day week programme focused on meaningful activities that meets the individual abilities and recreational preferences. The individual care plans include activities over a 24 hour period. Caregivers provide activities and the service has initiated employment of an intern.

The service medication management policies and procedures follow recognised standards and guidelines for safe medicine management practice. The general practitioner reviews medication charts three monthly.

Meals are prepared and cooked off-site by contractors. Individual and special dietary needs are accommodated. There are nutritious snacks available 24 hours per day.

## 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 building holds a current warrant of fitness. A maintenance manager oversees the reactive and planned maintenance. Hot water temperatures are monitored. Residents are able to bring their own possessions and adorn their room as desired. The facility is spacious with communal areas that are easily accessible. There are large grounds and gardens that are safe and secure. Seating and shade is available. Chemicals are stored safely throughout the facility. There is adequate heating, ventilation and natural light in bedrooms and communal areas. The facility was clean and well presented.

## 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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Brian Wells continues to provide a restraint free environment. There is a restraint policy that included comprehensive restraint procedures and aligns with the standards. There are no residents using enablers.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. Documented policies and procedures are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. Infection control education is provided to all staff as part of their orientation and also as part

of the on-going in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Results of surveillance are acted upon, evaluated and reported to relevant personnel.

## Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

<b>Attainment Rating</b>	<b>Continuous Improvement (CI)</b>	<b>Fully Attained (FA)</b>	<b>Partially Attained Negligible Risk (PA Negligible)</b>	<b>Partially Attained Low Risk (PA Low)</b>	<b>Partially Attained Moderate Risk (PA Moderate)</b>	<b>Partially Attained High Risk (PA High)</b>	<b>Partially Attained Critical Risk (PA Critical)</b>
<b>Standards</b>	2	43	0	0	0	0	0
<b>Criteria</b>	3	90	0	0	0	0	0

<b>Attainment Rating</b>	<b>Unattained Negligible Risk (UA Negligible)</b>	<b>Unattained Low Risk (UA Low)</b>	<b>Unattained Moderate Risk (UA Moderate)</b>	<b>Unattained High Risk (UA High)</b>	<b>Unattained Critical Risk (UA Critical)</b>
<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>Discussions with staff (two caregivers, the assistant care lead and one registered nurse) confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Five relatives were interviewed and confirmed the services being provided are in line with the Code.</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</p>	FA	<p>The informed consent policy includes responsibilities and procedures for staff. Informed consent information is provided to family/whanau on admission. Written general consent has been signed by the family in all resident files sampled. Two caregivers and the registered nurse (RN) interviewed were able to describe resident choice and informed consent (as appropriate) when delivering resident cares.</p> <p>Files include a resuscitation decision form. The GP discusses resuscitation with the family/whanau where the resident is deemed incompetent to make a decision.</p> <p>D3.1.d: Discussion with five family members identifies that the service actively involves them in decisions that affect</p>

<p>to make informed choices and give informed consent.</p>		<p>their relative's lives. D13.1: There were five signed admission agreements sampled.</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>	<p>FA</p>	<p>Contact numbers for advocacy services are included in the policy, in the resident information folder and in advocacy pamphlets that are available at Brian Wells. Discussions with relatives identified that the service provides opportunities for the family/EPOA to be involved in decisions.</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>	<p>FA</p>	<p>Relatives confirmed that visiting can occur at any time. Key people involved in the resident's life have been documented in the care plans. Relatives verified that residents have been supported and encouraged to remain involved in the community. Entertainers have been invited to perform at the service.</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>	<p>FA</p>	<p>A complaints policy and procedures have been implemented and residents and their family/whanau have been provided with information on admission. Complaint forms are available at the service. Staff are aware of the complaints process and to whom they should direct complaints. A complaints folder has been maintained. Three complaints were received in 2014. Systems and processes have been in place and documented to confirm that all complaints received are managed and resolved appropriately. Family members advised that they are aware of the complaints procedure and how to access forms.</p> <p>E4.1biii: There is written information on the service philosophy and practices particular to the dementia unit included in the information pack.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>The service provides information to residents that include the Code, complaints and advocacy. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Relatives interviewed identified they are well-informed about the code of rights. The family survey provides the opportunity to raise concerns. Advocacy and code of rights information is included in the information pack.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>Staff interviewed were able to describe the procedures for maintaining confidentiality of resident records, resident's privacy and dignity. House rules and a code of conduct are signed by staff at commencement of employment. Church services are held weekly and resident files include cultural and spiritual values. Contact details of spiritual/religious advisors are available to staff. Relatives interviewed reported that residents are able to choose to engage in activities and access community resources. There is an elder abuse and neglect policy and staff education and training on abuse and neglect has been provided.</p> <p>E4.1a The five family members interviewed stated that their family member was welcomed into the unit and personal pictures were put up to assist them to orientate to their new environment.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>The service has a Maori health plan and policies that include cultural safety and awareness. Discussions with staff confirmed their understanding of the different cultural needs of residents and their whānau. There are currently no residents at Brian Wells who identify as Maori. The service has established links with local Maori and an organisational Kaumatua. Staff confirmed they are aware of the need to respond appropriately to maintain cultural safety.</p>
<p>Standard 1.1.6: Recognition And</p>	<p>FA</p>	<p>Care planning includes consideration of spiritual, psychological and social needs. Relatives interviewed indicated that they are asked to identify any spiritual, religious and/or cultural beliefs for the resident. Relatives reported that</p>

<p>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>		<p>they feel they are consulted and kept informed and family involvement is encouraged.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>The staff employment process includes the signing of house rules and a service code of conduct. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues. The orientation programme provided to staff on induction includes an emphasis on dignity and privacy and boundaries. Registered nursing staff have completed training around professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The quality programme has been designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Staffing policies include pre-employment, and the requirement to attend orientation and on-going in-service training. The assistant care lead is responsible for coordinating the internal audit programme. Staff meetings are conducted and the services are supported by other services on the site. Relatives interviewed spoke very positively about the care and support provided. Staff have a sound understanding of principles of aged care and state that they feel supported by the assistant care lead. Care staff complete competencies relevant to their practice.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and</p>	<p>FA</p>	<p>Family members interviewed stated they are informed of changes in health status and incidents/accidents. This is confirmed on the 10 incident forms sampled. Family members also stated they and residents were welcomed on entry and were given time and explanation about services and procedures. The assistant care lead has an open-door policy. Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The service has policies and procedures available for access to interpreter services for residents (and their family/whānau). If residents or family/whanau have difficulty with written or spoken</p>

provide an environment conducive to effective communication.		English the interpreter services are made available.
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Brian Wells 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 16 residents requiring secure dementia level care. On the day of the audit, there were 14 residents.</p> <p>The organisation undertook a restructure in 2014. The aged care facilities on the site, including Brian Wells are overseen by the assistant village manager. Who has a business studies BA degree and a post graduate Diploma in Housing. She has previously managed another Selwyn site for three years. She is supported at Brian Wells by an assistant care lead that is a registered nurse and has had this role or its equivalent at Brian Wells for six years. The current business plan has been implemented including a number of actions with timeframes for Brian Wells.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	In the event of the assistant care lead being temporarily on leave a registered nurse from the Selwyn bureau would provide care with support from the assistant village manager and the clinical nurse specialist.
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality</p>	CI	<p>The quality plan describes the Brian Wells quality improvement processes. The organisation wide risk management plan describes objectives, management controls and assigned responsibility. Progress with the quality and risk management programme has been monitored through the staff meeting and input from the organisations quality manager. All quality data is electronically logged and monitored by the assistant care lead, the quality manager and the assistant village manager. Meeting minutes have been maintained and staff are expected to read the minutes. Minutes sighted have included actions to achieve compliance where relevant. Discussions with staff confirmed their involvement in the quality programme. Data is collected on complaints, accidents, incidents, infection control and restraint use (which is nil). The internal audit schedule for 2014 has been completed and for 2015 is underway.</p>

<p>and risk management system that reflects continuous quality improvement principles.</p>		<p>Areas of non-compliance identified at audits have been actioned for improvement. Specific quality improvements have been identified and benchmarking with other facilities occurs on data collected. Brian Wells exceeds the standard around quality and risk management processes. The service has implemented a health and safety management system. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. The service has comprehensive standard operating procedures to support service delivery. Policies and procedures align with the client care plans. A document control policy outlines the system implemented whereby all policies and procedures are reviewed regularly. There is a death/Tangihanga policy and procedure that outlines immediate action to be taken upon a consumer's death. Falls prevention strategies are implemented for individual residents. Relatives' are surveyed to gather feedback on the service provided and the outcomes are communicated to staff and families.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>CI</p>	<p>Incident and accident data has been collected and analysed (link 1.2.3.6). Discussions with the service confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. The DHB has been notified of three critical incidents. A sample of resident related incident reports for January, February and March 2015 were reviewed. All reports and corresponding resident files reviewed evidence that appropriate clinical care has been provided following an incident. The incident reporting policy includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. The service benchmarks incident data with other facilities in the Selwyn Foundation group. Brian Wells exceeds the standard around management of incidents, particularly critical incidents.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment</p>	<p>FA</p>	<p>The recruitment and staff selection process requires that relevant checks have been completed to validate the individual's qualifications, experience and veracity. Copies of practising certificates are kept. Five staff files were reviewed and included all appropriate documentation. Staff turnover was reported as low, with some staff having been employed in excess of 10 years. The service has a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Annual appraisals are conducted for all staff. A completed in-service calendar for 2014 exceeded eight hours annually and the 2015 in-service programme is being completed. The service exceeds the standard around staff training. The assistant care lead and enrolled nurse are provided with ongoing training relevant to the roles within the wider group.</p>

<p>practice and meet the requirements of legislation.</p>		<p>E4.5d: The orientation programme is relevant to the dementia unit and includes a session on how to implement activities and therapies.</p> <p>E4.5e: The service uses regular agency staff from the organisations bureau. All are well orientated to the unit.</p> <p>E4.5f: There are 13 caregivers who work in the dementia unit. All 13 have completed the required dementia standards.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>Brian Wells has a weekly roster in place which provides sufficient staffing cover for the provision of care and service to residents. The assistant care lead (a registered nurse) works full time Monday to Friday and is supported by an enrolled nurse who works over three days including the weekend. There is registered staff available on call on the site 24 hours per day. Caregivers and family interviewed advised that sufficient staff are rostered on for each shift. All staff have been trained in first aid and CPR.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>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. Paper and electronic files are used. Residents' files are protected from unauthorised access by being locked away in the nurses' stations and electronic records are password protected. Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. Record entries are legible, dated and signed by the relevant staff member. Individual resident files demonstrate service integration. Medication charts have been stored in a separate folder.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated</p>	<p>FA</p>	<p>Prior to entry, all potential residents have current needs assessment (within two weeks) completed to assess suitability for entry to the service. The assistant care lead screens all potential residents in discussion with the need assessor to ensure the service can meet the resident's specific needs. The service has an admission policy, admission agreement and a resident information pack available for families at entry. Five relatives interviewed stated they received sufficient information and had the opportunity to discuss the admission agreement with the</p>

<p>in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>		<p>assistant care lead.</p> <p>D13.3: The admission agreement reviewed aligns with a) -k) of the ARC contract. Admission agreements sighted were all signed on admission or prior to admission.</p> <p>D14.1: Exclusions from the service are included in the admission agreement.</p> <p>D14.2: The information provided at entry includes examples of how services can be accessed that are not included in the agreement.</p> <p>E3.1: Resident files sampled all included a needs assessment which identified them as requiring specialist dementia care.</p> <p>E4.1.b: Family/whanau with relatives accessing the specialist dementia unit are provided with written information on the service philosophy and practices particular to the unit which is included in the information pack.</p>
<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 transfer and discharge procedures in place. Inter-facility transfers and transfers to hospital are planned and coordinated in consultation with the family/whanau as appropriate. All relevant information is documented and communicated to the receiving health provider or service. Follow up occurs to check that the resident is settled, or in the case of death, communication with the family is made and this is documented.</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>All medication is managed appropriately in line with required guidelines and legislation. The RN, enrolled nurse and caregivers responsible for the administering of medication complete medication competencies and attend annual medication education. The RN checks all medications (robotic sachets) on delivery against the medication chart. All medication sighted was within the expiry dates and all eye drops were dated on opening. There were no self-medicating residents. The standing orders are current. Ten medication charts sampled meet legislative prescribing requirements. The GP had reviewed the medication charts at least three monthly.</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>An external contractor provides all meals. Currently meals are supplied from an off-site service while the new main kitchen is built on-site. Meals are delivered in hot boxes to the unit kitchenette. All meals are served by contracted kitchen hands. The resident likes and dislikes are known. Alternative choices are offered for dislikes. The menu has had dietitian input. The dietitian is involved for any residents with weight loss. The midday meal was observed with staff assisting residents as required.</p> <p>Fridge, freezer, dishwasher and serving temperatures are checked and recorded daily. D19.2k Kitchen staff have completed food handling training and chemical safety.</p> <p>E3.3f, Additional nutritional snacks are readily available for the residents.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>The service has accepting/declining entry to service policies. Entry is declined if there are no beds, or the resident needs assessment is inappropriate for the level of care provided. The referrer is informed within a timely manner.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>The RN completes an assessment within 24 hours of admission. A range of assessment tools as applicable are completed on the system (sighted) and reviewed six monthly. The outcomes of the assessments were reflected in the resident care plans.</p> <p>E4.2: Residents files sampled had individual assessments that included identifying diversional, motivation and recreational requirements.</p> <p>E4, 2a: Challenging behaviour assessments were completed on initial assessment. Care plans describe interventions for de-escalation of behaviours and diversional therapy activities over a 24 hour period.</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>The registered nurse develops the long term care plan from information gathered from staff, family/whanau and allied health professionals involved in the care of the resident. Long term care plans viewed on the system describe the support required to meet the individual needs of the resident. A care summary is printed off and placed in the resident file to guide caregivers for care delivery. Family members interviewed confirmed they were kept well informed and involved in all aspects of care planning for their family/whanau member.</p> <p>E4.3: Resident records identify current abilities, level of independence, identified needs and specific behavioural management strategies.</p> <p>D16.3k: Acute care plans are used for changes of resident health status.</p> <p>D16.3f: Resident records reviewed identified that family/whanau are involved in the care planning process.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>The service provides care for residents requiring dementia level of care. Individualised care plans are completed by registered nurse. When a resident's condition alters, the registered nurse or assistant care lead initiate a review and if required GP or specialist consultation is actioned.</p> <p>D18.3 and 4. Dressing supplies are available. There were wound assessments, wound treatment and evaluation forms for five skin tears. Continence products are available Bowel records are maintained. Specialist continence and wound care advice is available as needed and this could be described by the registered nurse.</p> <p>The physiotherapist is involved in mobility assessments and post falls assessments.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The service employs a qualified diversional therapist (DT) who oversees all the site activity programmes and meets with the assistant care lead. The DT (interviewed) has been with the service five years. The programme is flexible and includes everyday activities (baking, crafts, walks and reminiscing). Caregivers with the assistance of a volunteer coordinate activities based on individual preferences and one on one time.</p> <p>Family/whanau are encouraged to participate in activities with their loved ones. Theme days, cultural days and events are celebrated. There are twice weekly van outings.</p> <p>Family input is sought to complete a resident lifestyle questionnaire. Individual activities are incorporated into the care plans and reviewed six monthly. Resources are readily available for caregivers.</p> <p>A psychology student with the local university spent a year volunteering at Brian Wells and has in February 2015 been employed for 16 hours a week. This internship is a new initiative for the Selwyn organisation. His role is primarily to work with families to develop very individualised plans for residents based on their past interests and engage residents in meaningful daily activities of living whilst study the effects on reducing behaviours. The</p>

		internship is for one year.
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Evaluation timeframes are specified in policies and procedures. Initial care plans sighted were evaluated by the RN within three weeks. There are six monthly written evaluations sighted on the system. Allied health professionals involved in the care of residents are notified regarding input into care plan reviews. Family/whanau are invited to provide input into the care plan review and receive copies of the care plan.</p> <p>D16.4a Care plans are evaluated by the registered nurse at least six monthly or when changes to care occurs for residents.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>The service facilitates access to other medical and non-medical services. Referral documentation and communications with family/whanau are maintained on resident files.</p> <p>D 16.4c: The RN and assistant care lead (RN) are aware of the need to refer residents for re-assessment should there be a significant change in the resident's level of need and those needs can no longer be met by the service.</p> <p>D 20.1: Discussion with the registered nurse identified that the service has access to primary care and specialist medical services including specialist mental health for older person's services, consultant psychiatrist, dieticians, wound care and continence nurse specialists.</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</p>	FA	<p>There is a waste management policy and procedure that outlines processes and reporting requirements. All chemicals are supplied in correctly labelled containers which includes information on safe use. Personal protective equipment is available for use by staff. Chemicals are stored safely throughout the facility. Staff have attended chemical safety training.</p>

<p>exposure to waste, infectious or hazardous substances, generated during service delivery.</p>		
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>There is a current building warrant of fitness which expires on 16 January 2016. The full time maintenance manager is responsible for reactive and planned maintenance. Requests are logged into the on-line system and allocated to the appropriate team member. Preferred contractors are available 24/7. Electrical testing and tagging and clinical equipment have been checked. There is safe indoor/outdoor access. Seating and shade is provided.</p> <p>E3.3e: Residents (and their visitors) may use their bedrooms for privacy when required. Large outdoor areas provide low stimulus and quiet areas.</p> <p>E3.3d The facility provides for dementia care only.</p> <p>E3.4.c: There are secure outdoor gardens, grounds and safe pathways that are easily accessed by residents.</p> <p>E3.4d: The main lounge is designed so that space and seating arrangements provide for individual and small group activities. There is a sunroom also available for quiet time or one on one activity.</p> <p>D15.3b: The RN and caregivers (interviewed) stated that they have all the equipment and resources required to deliver safe care. Strategies for the provisions of a low stimulus environment could be described by staff.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene</p>	<p>FA</p>	<p>There are adequate numbers of communal toilets and bathrooms throughout the facility. Communal toilets and bathrooms have appropriate signage. The location of the toilet facilities is easily accessible from the communal areas.</p> <p>Flooring, fixtures and fittings are appropriate. All communal toilets have hand washing and drying facilities. All bedrooms have hand basins.</p>

requirements.		
<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	<p>All bedrooms are single. The bedrooms are of sufficient size to be able to safely move around the bedroom with the use of mobility aids and allow a degree of personal space. Residents are able to bring their own possessions including furniture to their bedroom. Bedroom flooring is a mix of carpets and vinyl's.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>There is a main lounge, seating alcoves and sunroom for residents. There is a dining area. Communal areas are centrally located within the unit. The lounges and dining room are easily accessible for the residents. Activities occur throughout the facility. Residents are able to move freely and furniture is well arranged to facilitate this. Seating and space is arranged to allow both individual and group activities to occur.</p> <p>E3.4b: There is adequate space to allow maximum freedom of movement while promoting safety for those that wander.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being</p>	FA	<p>The facility has housekeeping and laundry policies and procedures and ensures all cleaning and laundry services are maintained and functional at all times. Woollens only are laundered on-site. All other linen and personal clothing is out-sourced. Clean linen is delivered in bed and shower bundles. The unit has a sluice room. Care staff carry out cleaning duties. Equipment is stored safely. Quality control audits are carried out by the chemical provider.</p>

provided.		
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>The service has a fire and emergency procedures manual. The fire evacuation scheme was approved in 1993. The New Zealand Fire Service has approved the current evacuation scheme. There is a staff member with a first aid certificate on each shift. Fire safety training has been provided. Call bells are available. Visitors and contractors sign in at reception when visiting. Fire drills have been conducted six monthly. Civil defence and first aid resources were available. Sufficient water is stored for emergency use and alternative heating and cooking facilities are available. Emergency lighting is installed.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>Living areas and resident bedrooms have adequate light and are appropriately heated and ventilated. All resident designated rooms had a window that provided both natural light and view to the outside.</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</p>	FA	<p>Brian Wells has an established infection control (IC) programme. The infection control programme has been appropriate for the size, complexity and degree of risk associated with the service and is linked into the incident reporting system electronic database. The assistant care lead (a registered nurse) has been the designated infection control nurse with support from the infection control team in the organisation and the clinical nurse specialist. All infection control matters are discussed in staff meetings. Minutes are available for staff. There are six monthly organisation wide infection control meetings. Regular audits have been conducted and education has been provided for staff. The infection control programme has been reviewed annually.</p>

appropriate to the size and scope of the service.		
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>There are adequate resources to implement the infection control programme at Brian Wells. The infection control (IC) nurse has maintained her practice by attending infection control updates. External resources and support are available when required. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service</p>	FA	<p>The infection control manual outlines a comprehensive range of standard operating procedures, standards and guidelines and includes roles, responsibilities, procedures, the infection control team and training and education of staff. The policies are reviewed and updated at least two yearly.</p>

provided.		
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The facility is committed to the on-going education of staff and residents. Education is facilitated by the infection control nurse. All infection control training has been documented and a record of attendance has been maintained. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak had been resolved (there have been no recent outbreaks). Information is provided to residents and visitors that are appropriate to their needs and this was documented in medical records. Education around infection prevention and control has been provided in 2014 and 2015.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Infection surveillance and monitoring is an integral part of the infection control programme and is described in infection monitoring policy. The assistant care lead is the designated infection control nurse. Monthly infection data is collected for all infections based on signs and symptoms of infection. All infections are individually logged on the electronic database. The data has been monitored and evaluated monthly and annually at facility and organisational level.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Brian Wells continues to provide a restraint free environment. There is a restraint policy that included comprehensive restraint procedures and aligns with the standards. There are no residents using enablers. Staff are trained in the management of behaviours that challenge.</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 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	CI	<p>There is a comprehensive quality and risk management process in place. The service monitoring programme includes (but not limited to); environment, kitchen, medications, documentation, moving and handling, Code</p>	<p>There are a number of on-going quality improvements identified through meeting minutes and as a result of analysis of quality data collected. Brian Wells is proactive in developing and implementing quality initiatives. Regular staff meetings include feedback on quality data where opportunities for improvement are identified. A review of quality improvement plans and discussion with the assistant care lead demonstrates that there is comprehensive analysis of clinical indicators and other areas such as education/competencies. Quality improvement plans have been established on a regular basis where Brian Wells is above the benchmark. i.e.: August and September 2014 Brian Wells was above the upper control for total incidents with seven incidents in August 2014. The quality improvement plan that was implemented included analysing each incident and identifying any trends and providing education to relatives as this was a common factor in some incidents. Brian Wells has remained below the benchmark for total incidents since October 2014. A further example is Brian Wells being above the benchmark for falls in October 2014. A quality improvement plan was raised by the quality manager with all falls being analysed resulting in reassessment for four residents to hospital level care, discussing staff monitoring at staff meetings and ensuring residents at risk have hip protectors.</p>

		<p>of rights, care planning and infection control.</p> <p>Monitoring in each area is completed monthly, quarterly, six monthly or annually as designated by the internal auditing programme schedule.</p> <p>All audit results are reported to the quality manager and a quality improvement plan is developed with completion being the responsibility of the assistant care lead and monitored by the assistant village manager and quality manager.</p> <p>There is also a number of on-</p>	
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		<p>going quality improvements identified through meeting minutes and as a result of analysis of quality data collected. Staff meetings include excellent feedback on quality data where opportunities for improvement are identified.</p> <p>The service is active in analysing data collected. Quality indicators are provided to the benchmarking programme. Feedback is provided to Brian Wells via graphs and benchmarking results are discussed. Quality improvement</p>	
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		plans are completed where benchmarking was above i.e.: total incidents being above the upper control in August and September 2014.	
<p>Criterion 1.2.4.3</p> <p>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.</p>	CI	<p>When an incident occurs the staff member finding the incident completes and incident form. Urgent matters after hours are dealt with by the on call registered nurse or by the assistant care lead during business hours. All incidents are electronically logged and quality improvement plans are raised when</p>	<p>The service actively investigates critical incidents. In February 2013, the organisation decided to review the whole incident reporting process, particularly on how they dealt with serious complaints &amp; incidents, from the depth of an investigation, the support required and the process for benefiting from organisation learning. . A review of the procedure resulted in a standard operating procedure being developed and implemented. At this time a critical incident register was developed. The policy includes definitions for critical incidents. When a critical incident occurs the quality manager and assistant village manager are automatically notified when the incident is logged in the electronic database (which occurs on the day of the incident). At this time a member of the senior leadership team in the organisation to monitor/lead the process for that incident. This ensures that the support office is aware of the incident and can be supportive and pro-active in implementing changes. It enables a senior leader to experience and see happenings on the frontline. The incident remains on the critical incident risk list until resolved and review occurred. The reviews for each incident are attended by key personnel involved in the incident and processes are looked at from both a facility level but from a company level.</p> <p>Two examples of the process being implemented at Brian Wells include one critical incident that resulted in changes to the transfer and discharge policy, a process to ensure residents have the appropriate hip protectors for their needs, ensuring that all information and equipment is transferred when a resident is transferred and discussion and staff training around pain management and general care. The second critical incident for which detailed analysis occurred during the audit resulted in staff training around documentation and the bowel record being printed off at morning handover and discussed so that all staff are aware of residents needs in this area.</p>

		required. Incidents are benchmarked.	
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	CI	The service ensures that staff are trained by providing training according to set schedules and providing training in small groups to maximise staff understanding of the subject.	<p>Selwyn Foundation has reviewed and changed the ways in which training are delivered in 2014 and 2015. Core training is now delivered over four modules using a train the trainer method. The assistant care lead has been trained to deliver the modules. The health, safety and wellbeing module was delivered in 2014 and covers safety in the workplace, hazard management, risk management, incident reporting, fire and emergency procedures, moving and handling, management of waste and hazardous substances, wellbeing, bullying and harassment and managing stress for wellness. The person centred care module was delivered to nine staff during March 2014 and includes the Selwyn Foundation mission, person centred care, the Eden alternative, code of rights, abuse and neglect, advocacy, culturally safe care, sexuality and intimacy, care planning, maximising independence, privacy and dignity and death and dying. The clinical care module was delivered to five staff in November 2014 and covers resuscitation, continence, pain management, skin integrity and wound management, nutrition and hydration, dementia and challenging behaviours and palliative care. The communication and documentation in practice module was delivered to seven staff in April 2014. It covers communication, listening skills, documentation, clinical records, principles of clinical documentation – paper based and computerised, messages, incident reporting, hazard reporting, complaints and compliments and responding to feedback and privacy and confidentiality. The assistant care lead identified in early 2014 that while staff were attending all mandatory training days they did not all appear to be implementing the material taught. Her investigation into this showed that many staff struggled to learn in large groups. In response to this each of the modules have been delivered to staff in small groups of two or three staff. The organisation also offers a business communication course to assist staff to improve the communication skills relating to the care environment. Five Brian Wells' staff are enrolled to complete this in 2015 following positive feedback from others who have attended. When issues are identified a MoE training method is used with memos being placed in the memo folder and which must be read and signed as understood by all staff. The assistant care lead goes over this information with staff. Examples that have been taught with memos in 2014 and 15 include the use of low low beds (from a benchmarking quality improvement plan), soft sided hip protectors (from a critical incident) and bowel management (from a critical incident – link 1.2.3.6). All training is logged on a database and monitored by the organisations quality coordinator. The two caregivers and registered nurse interviewed report that while staff training was always good it is now more directed at the specific needs of staff at the Brian Wells unit.</p>

End of the report.