# Selwyn Care Limited - Caswell House

## Introduction

This report records the results of a Surveillance 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:** Caswell House

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 3 June 2015 End date: 4 June 2015

**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:** 49

# 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

Caswell House is owned and operated by the Selwyn Foundation. The service provides rest home care for up to 52 residents. On the day of audit there were 49 residents. The care lead (registered nurse) was appointed nine months ago and has previous experience within the Selwyn group as a clinical coordinator. She is supported by an assistant village manager, clinical nurse specialist and two part time registered nurses.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the District Health Board.  This audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management and staff.

The service has continued to implement a number of quality improvements.

The previous certification shortfall around care plan evaluations has been addressed.

This audit identified an improvement required around interventions and aspects of medicine management.

The service has continued to exceed the standard around governance, quality and risk management and activities.

## Consumer rights

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

The service practices open communication with residents and families and there is documented evidence of relative notification for any changes in health status. 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. |

Caswell House 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 rest home and hospital level of care. Staffing is based on the occupancy and acuity of the residents.

## Continuum of service delivery

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

Assessments, care plans and evaluations are completed by the registered nurses. Residents/relatives/whanau are involved in planning and evaluating care. Care 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. Short term care plans are available for use for short term needs. Residents and family interviewed were very complimentary about the care received.
The activity coordinator and Selwyn Village diversional therapist provide a seven day week programme focused on meaningful activities that meet the individual abilities and recreational preferences. Community links are maintained. The service has a group of volunteers involved in the activity programme.

The service operating procedures align with recognised standards and guidelines for safe medicine management. The general practitioner reviews medication charts three monthly.
Meals are prepared and cooked off-site by contractors. Individual and special dietary needs are accommodated.

## Safe and appropriate environment

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| --- | --- | --- |
| 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 building holds a current warrant of fitness.

## Restraint minimisation and safe practice

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| --- | --- | --- |
| 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. |

There is a restraint policy that included comprehensive restraint procedures and aligns with the standards. There were no residents using enablers or restraints. Staff receive ongoing restraint education.

## Infection prevention and control

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| --- | --- | --- |
| 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. |

The infection control programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service. The service has an Infection control co-ordinator with defined responsibilities. Reports and surveillance data are discussed at staff meetings. 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.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **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** | 3 | 11 | 0 | 1 | 1 | 0 | 0 |
| **Criteria** | 4 | 33 | 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 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | 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. Residents interviewed confirmed they received information on the complaints process on admission and the care lead is very approachable should they have any concerns/complaints. Staff (seven healthcare assistants) interviewed are aware of the complaints process and to whom they should direct complaints. A complaints folder has been maintained. There has been one complaint received to date for 2015. The verbal complaint has been managed appropriately and to the satisfaction of the complainant. The complaints register is up to date.  |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | One rest home family member stated they are kept informed of changes in health status and incidents/accidents. Relative notification was evidenced on the seven incident forms sampled. Families receive information and explanation on the services provided at Caswell House. Five residents and one family member state the care lead has an open door policy and is available at any time should they have concerns. New residents receive an orientation to the facility and have a “buddy” to guide and assist them during their transition to rest home care. Resident and family meetings are monthly. 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 standard operating procedures available for access to interpreter services for residents (and their family/whānau). If residents or family/whanau have difficulty with written or spoken English the interpreter services are made available. |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | CI | Caswell House is owned and operated by the Selwyn Foundation and is one of four current services operating from the village site. The service provides care for up to 52 residents requiring rest home level care. On the day of the audit, there were 49 rest home residents.The aged care facilities on the site, including Caswell House are overseen by the assistant village manager who has a degree in business studies and a post graduate Diploma in Housing. She has previously managed another Selwyn site for three years. She is supported at Caswell House by a care lead (CL) who is a registered nurse and was appointed to the role in September 2014. She has previously worked as a clinical coordinator at another Selwyn facility. The CL has completed orientation to the role including relevant competencies. The CL has completed a post graduate certificate in Health services (May 2015), InterRAI training and has a current first aid certificate. The Selwyn Care foundation has an overarching five year strategic business plan. Caswell House has a 2015 specific quality plan including a number of actions with timeframes. The Caswell House 2014 plan has been reviewed. The service has continued to exceed in this standard. |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | CI | The quality plan describes the Caswell House 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 key staff meeting, staff meetings and input from the organisations quality manager. All quality data is electronically logged and monitored by the 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. Specific quality improvements have been identified and benchmarking with other facilities occurs on data collected. 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. There is a current hazard register reviewed March 2015. All of Selwyn care health and safety representatives meet for a six monthly forum which includes training and updates. 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. Falls prevention strategies are implemented for individual residents. Relatives and resident surveyed was last conducted November 2013. Results were collated by an external agency with an overall analysis for each survey category with ranking within the company. The 2014 survey was delayed due to the village re-structure however has been re-scheduled for 2015.  |
| 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.  | FA | Seven accident/incident forms for the month of May 2015 were sampled. There has been RN notification and clinical assessment completed within a timely manner. Accidents/incidents were recorded in the resident progress notes. There is documented evidence the family/whanau had been notified. D19.3c: The service collects incident and accident data and reports aggregated figures monthly to the Selwyn management. Staff confirmed incident and accident data is discussed at the staff meeting. D19.3b: The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Trending data is considered. Critical incidents are also discussed at group clinical leads monthly meeting. Discussion with the clinical leader confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications |
| 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 | The recruitment and staff selection process requires that relevant checks have been completed to validate the individual’s qualifications, experience and veracity. A copy of practising certificates is kept. Five staff files were reviewed and included all appropriate documentation. Staff turnover was reported as low, with a number of long serving staff. 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. Training is delivered in four one day modules per year that covers compulsory education requirements. The care lead is provided with ongoing training relevant to the role within the wider group.  |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | Caswell House roster identifies there is sufficient staffing cover for the provision of care for rest home residents. The care lead (a registered nurse) works full time Monday to Friday and is available on-call. She is supported by a RN team leader and a senior care supervisor (health care assistant) Monday to Sunday. Caregivers and family interviewed advised that sufficient staff are on the roster for each shift. Selwyn Foundation has its own bureau of nursing staff to cover sick leave and annual leave.  |
| Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate | The RN’s and senior HCAs responsible for the administering of medication complete annual medication competencies and attend annual medication education. All medications sighted were within the expiry dates. The pharmacy completes a six monthly stocktake. There were two self-medicating residents who had self-medication competencies completed and monitored as per self-medication policy. The standing orders are current. Ten medication charts were sampled. All medication charts had photo identification and allergy status noted. The GP had reviewed the medication charts at least three monthly.  |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | An external contractor provides all meals from an on-site main kitchen. A four weekly menu has recently been reviewed by a dietitian. Meals are delivered in hot boxes and served from the bain marie in the facility kitchenette. All meals are served by contracted kitchen hands. The resident likes and dislikes are known and accommodated. Alternative choices are offered for dislikes. The head chef visits the facility at least weekly to monitor the service including meeting with residents and receiving feedback on the meals. The external contractor is responsible for ensuring compliance with food safety standards including hot food temperature monitoring. Fridge and freezer temperature monitoring has been conducted. Chemicals are stored safely. Residents interviewed commented positively on the food services. D19.2k Kitchen staff have completed food handling training and chemical safety.  |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Low | Residents state their needs are being met. The HCAs and the RN stated that they have all the equipment and resources required to deliver safe care. Four of five resident files sampled did not have documented interventions to meet their current needs. D18.3 and 4: Dressing supplies are available. There were three minor wounds. Wound assessment, wound management plans and short term care plans were in place for all wounds.Specialist continence and wound care advice is available as needed and this could be described by the registered nurse and care lead.  |
| Standard 1.3.7: Planned ActivitiesWhere 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. | CI | The activity coordinator has been in the role for two years. She is a caregiver with a nationally recognised qualification in aged care. She has also completed the course on the Eden philosophy. The activity coordinator is employed for 32 hours per week Tuesday to Saturday. A diversional therapy (DT) works Sunday and Monday at Caswell and is available to mentor and support the activity coordinator during the week. The activity coordinator attends monthly DT programme meetings, on-site education and has a current first aid certificate. There are three volunteers who also assist with activities. The programme is planned monthly however is flexible to meet resident choice and preference. Special events and theme days are celebrated. Community involvement is encouraged such as Girl Guides, charity groups and church visitors. A van is available monthly for outings. Inter-denominational church services are held twice weekly. Residents were observed participating in activities on the days of audit. Resident meetings are held monthly and provide a forum for feedback relating to activities. Residents and family members interviewed discussed enjoyment in the programme and the diversity offered to all residents. Activity plans are reviewed six monthly at the same time as the care plans. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Evaluation timeframes are specified in policies and procedures. Initial care plans sighted were evaluated by the RN within three weeks. Care plan evaluations were completed in four of five resident files sampled. One resident had not been at the service long enough for an evaluation. D16.4a Care plans are evaluated by the registered nurse at least six monthly or when changes to care occurs for residents. Staff document progress in each resident’s clinical record daily and as changes occurs. A three monthly review by the medical practitioner occurs for all medically stable residents or more frequently if a resident's health is more complex. Short term care plans sighted for short term needs had been reviewed regularly. Assessment tools are evaluated at the time of care plan review or earlier due to health changes. The previous finding around evaluation of assessment tools has been addressed. Family/whanau are invited to provide input into the care plan review and receive a copy.  |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | There is a current building warrant of fitness which expires on 28 May 2016.  |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections and definition of infections. The infection control coordinator (care lead/RN) uses the information obtained through surveillance to plan and determine infection control activities, resources, and education needs within the facility. An infection report form and short term care plan is completed for the management of a suspected/diagnosed infection. All infections are individually logged on the electronic database. Trends (monthly and yearly comparisons) and quality improvements have been identified and monitored. Corrective actions have been developed when needed, and implemented. Antibiotic use is monitored by the IC coordinator and GP. Staff interviewed confirmed they are kept informed on any infection control matters, trends, corrective actions and quality initiatives relating to infection control activities. Infection rates were low. Benchmarking occurs internally within the organisation and externally with another organisation. There have been no outbreaks.  |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | There is a restraint policy (reviewed August 2014) that included comprehensive restraint procedures and aligns with the standards. A registered nurse is the restraint coordinator. There are no enablers or restraints in use. Staff receive training in restraint and enablers on orientation and is ongoing. All Selwyn restraint coordinators meet six monthly, which includes training. Enablers/restraint are discussed at staff meetings.  |

# 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 1.3.12.1A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | The service receives robotic rolls of medication with the corresponding signing sheets. Prescribing requirements for regular medications and dietary supplements met legislative requirements.  | 1) There is no documented evidence medications are checked on delivery against the resident medication chart. 2) There are seven signing gaps on five out of 10 medication signing sheets sampled. 3) There are no signing sheets in place for two residents prescribed dietary supplements. 4) There are no indications for use of as required medications on three out of 10 medication charts.  | 1) Ensure there is documented evidence of medications checked on delivery against the medication chart. 2) Ensure medications are signed as given following administration. 3) Ensure dietary supplements are signed as given as per medication chart. 4) Ensure all as required medications have an indication for use. 30 days |
| Criterion 1.3.6.1The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Low | When a resident's condition alters, the registered nurse initiates a review and if required, GP or specialist consultation. The relative interviewed confirm they are kept informed on any changes to the resident condition and their relative needs were being met. | There were no documented interventions for the following resident’s needs 1) the management of hypoglycaemia (link tracer 1.3.3.) 2) The de-escalation of challenging behaviours 3) prevention of chronic urinary tract infections 4) no pain assessment for identified shoulder pain. The same resident did not have monthly weight recordings between December 2014 and May 2015 when weight loss was identified. There was no short term care plan in place for weight loss.  | Ensure there are documented interventions that reflect the resident’s current health status. 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 1.2.1.1The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed. | CI | Caswell House is owned and operated by the Selwyn Foundation and is one of four current services operating from the village site. The service provides care for up to 52 residents requiring rest home level care. On the day of the audit, there were 49 rest home residents.The organisation undertook a restructure in 2014.  | The service continues to exceed the standard around business goals and direction. The organisation has a strategic plan 2013-2017 that contains seven goals relating to: charitable mission, continuum of care, a centre of excellence, partnership (with key organisations, brand, environmental sustainability and financial strength. The strategic plan is reviewed regularly. Caswell House had a 2014 business plan with documented goals. The goals were formally reviewed six monthly (in June and December 2014) between the care lead and the assistant village manager. Goals achieved in 2014 included (but were not limited to): a) Continuing to foster Selwyn’s at home way with unique culture and home-like environment by: involvement, choices and cultural and spiritual needs being met in care planning b) rebuild customer confidence that Caswell can provide the service by: (i) reduction in laundry lost property (by use of a labelling machine) and timely delivery of clothes (there have been no complaints in this area); (ii) improved delivery of food services with a menu review to include a variety of cuisine, and staggered delivery times ensuring the meals are served at an acceptable temperature; (iii) education is being delivered in modules, which also includes staff wellness and train the trainer modules and; (iv) staff with English as second language have attended a 20 week government funded course which relates to healthcare. Staff and resident feedback is positive with increased communication skills and staff confidence. Examples of goals for 2015 include: a) streamlining all systems and process across all sites in the village enabling care leads to provide cover for each other; b) review of policies with wording for easier staff understanding; c) new laundry “roll out “with bar coding of personal clothing; d) advance care planning palliative care packages; e) appointment of village diversional therapist (DT) to work alongside the facility DT’s and coordinate services and training; and f) staff involvement in a project “connecting with the community”. Examples have included using the grounds for guide dog training and the service is planning to have community puppy classes on-site. |
| Criterion 1.2.3.1The organisation has a quality and risk management system which is understood and implemented by service providers. | CI | The service has continued to exceed in this standard.  | The service continues to exceed the standard around the quality and risk management system. Internal auditing, and the raising of ‘quality improvement plans’ (QIP’s) has continued to be developed and improved. When the restructuring occurred and new care lead’s (registered nurse managers) were appointed, the two day orientation in August 2014 included the internal auditing process and the raising of QIP’s. QIP’s continue to be managed through the organisational quality system. The care lead interviewed is very familiar with the quality and risk management process.  |
| Criterion 1.2.3.6Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | CI | There are a number of on-going quality improvements identified through meeting minutes and as a result of analysis of quality data collected. Caswell House is proactive in developing and implementing quality initiatives.  | There are a number of on-going quality improvements identified through meeting minutes and as a result of analysis of quality data collected. Caswell House is proactive in developing and implementing quality initiatives. Staff interviewed confirmed quality improvements and quality initiatives are discussed at staff meetings. Data is collected on complaints, accidents, incidents, health and safety and hazard management, infection control and restraint use. The internal audit schedule for 2014 has been completed and is in the process of being completed for 2015. Audits are delegated out to relevant personnel to complete. The organisations clinical nurse specialist (CNS) completes clinical audits. Areas of non-compliance (less than 100%) identified at audits have a quality improvement raised and these have been actioned for improvement. Examples of recent QIPs are around monthly weighing of residents and staff appraisals. Corrective actions have been put in action demonstrating service compliance. A critical incident process has been introduced within Selwyn Foundation. The CL attended critical incident training in March 2015. The service has reported three critical incidents. Quality improvements as a result of critical incident reporting, include a) the provision of emergency phones for all facilities and regular maintenance for all phone and computer systems following a system failure and b) introduction of an instruction and responsibility form for residents/families to sign when going on leave regarding medications. The care lead described the process and debriefing session as an opportunity for learning. CLs present case studies at the monthly CL and key staff meetings.  |
| Criterion 1.3.7.1Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | CI | The activity programme focuses on individual social and recreational preferences in line with the Eden philosophy known as the Selwyn way. The activity coordinator is an Eden Associate.  | The service continues to exceed the standard in activities. An increased improvement in communication (daily contact with residents and discussions about the activities for the day) has seen the residents become more involved in the programme and increased participation in activities of their choice. A number of new activities have been introduced including gardening with the gardener, arts, crafts and painting. There has been a greater emphasis on reminiscence and cultural themes to meet the individual recreational, physical and cognitive abilities. A member of the community visits fortnightly to involve the residents in Tai Chi. Caswell has launched SAFE (Selwyn animals for the elderly) with approved visiting animals. Able residents are encouraged to support other residents with activities. There is a 2015 goal to formalise the volunteer base and encourage those living in independent apartments to become involved in the Selwyn way.  |

End of the report.