

Selwyn Care Limited - Selwyn Oaks

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:	Selwyn Oaks
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 11 April 2016 End date: 12 April 2016
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:	63

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Selwyn Oaks is owned and operated by the Selwyn Foundation and cares for up to 66 residents requiring rest home or hospital level care. On the day of the audit, there were 63 residents. All residents were under the Age Related Care Contract.

The service is managed by a village manager who has both management and aged care experience. The care centre is overseen by the care lead who is a registered nurse with experience in aged care. She is supported by the group residential care manager. Residents, relatives and the GP interviewed spoke positively about the service provided.

This certification audit was conducted against the relevant Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of residents' and staff files, observations and interviews with residents, relatives, staff and management.

This audit has identified areas for improvement around the confidentiality of information, staff meeting minutes, timeliness of documentation, interRAI assessments, care planning and care interventions.

Consumer rights

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

Policies and procedures adhere with the requirements of the Code of Health and Disability Services Consumers' Rights (the Code). Residents and families are informed regarding the Code and staff receives ongoing training about the Code.

The personal privacy and values of residents are respected. There is an established Māori health plan in place. Individual care plans reference the cultural needs of residents. Discussions with residents and relatives confirmed that residents and where appropriate their families are involved in care decisions. Regular contact is maintained with families including if a resident is involved in an incident or has a change in their current health. Families and friends are able to visit residents at times that meet their needs. Examples of good practice were provided.

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

Organisational management

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

Services are planned, coordinated and are appropriate to the needs of the residents. A village manager and care lead are responsible for the day-to-day operations. Goals are documented for the service with evidence of regular reviews. A quality and risk management programme is embedded. Data is collected, analysed, discussed and changes made because of trend analysis. Corrective actions are implemented and evaluated where opportunities for improvements are identified.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. Ongoing education and training is in place, which includes in-service education and competency assessments.

Registered nursing cover is provided 24 hours a day, 7 days a week. Residents and families report that staffing levels are adequate to meet the needs of the residents.

The integrated residents' files are appropriate to the service type.

Continuum of service delivery

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

Service information is provided to residents and family on admission to services. Resident records reviewed provide evidence that the registered nurses utilise the interRAI and paper based assessments to assess, plan and evaluate care needs of the residents. Care plans are developed in consultation with the resident and/or family. Care plans demonstrate service integration and are

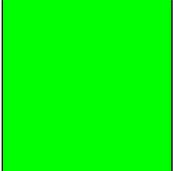
reviewed at least six monthly. Resident files include three monthly reviews by the general practitioner. There is evidence of other allied health professional input into resident care.

An integrated activities programme is implemented for the rest home and hospital residents. The programme includes community visitors, outings, entertainment and activities that meets the recreational preferences and abilities of the residents.

Medication policies reflect legislative requirements and guidelines. All staff responsible for administration of medicine completes education and medicine competencies. The medicines records reviewed include documentation of allergies and sensitivities and are reviewed at least three monthly by the general practitioner/nurse practitioner.

The menu is designed and reviewed by a registered dietitian and all meals are cooked on-site by an external contractor. Residents' individual needs are identified. There is a process in place to ensure changes to residents' dietary needs are communicated to the kitchen. Regular audits of the kitchen and meal service occur.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
--	--	--

The service displays a current building warrant of fitness. Furniture and fittings are selected with consideration to residents' abilities and functioning. Residents can and do bring in their own furnishings for their rooms. The service has policies and procedures for management of waste and hazardous substances and incidents are reported on in a timely manner. Staff receives training and education to ensure safe and appropriate handling of waste and hazardous substances. Documented policies and procedures for the cleaning services are implemented with monitoring systems in place to evaluate the effectiveness of these services. Laundry is completed off-site. Policies and procedures are in place for essential, emergency and security services, with adequate supplies should a disaster occur. There is staff on duty with a current first aid certificate.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
---	--	--

Staff regularly receives training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. A register is maintained by the restraint coordinator. No residents were using restraints and one resident was using an enabler.

Infection prevention and control

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

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner. There have been no outbreaks since the previous audit.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	39	0	5	1	0	0
Criteria	0	87	0	5	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](#).

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>Selwyn Oaks policies and procedures are being implemented that align with the requirements of the Code of Health and Disability Services Consumers' Rights (the Code). Families and residents are provided with information on admission, which includes information about the Code. Staff receives training about resident rights at orientation and as part of the annual in-service programme. Interviews with care staff (eight caregivers - three who work across the rest home and hospital, two from the rest home and three from the hospital, four registered nurses (RNs) and one activities coordinator) confirmed their understanding of the Code. Fifteen residents (seven rest home level and eight hospital level) and three relatives (two hospital level, one rest home level) interviewed confirmed that staff respect privacy and support residents in making choices.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed</p>	FA	<p>There are policies and procedures in place (standard operating procedures) around informed consent and resuscitation and the service is committed to meeting the requirements of the Code of Health and Disability Services Consumers Rights. There are signed general consents including outings on eight of eight resident files sampled (four rest home and four hospital level of care residents). Resuscitation treatment plans and advance directives were appropriately signed in the files reviewed.</p>

consent.		<p>Discussions with caregivers and registered nurses (RN) confirmed that they were familiar with the requirements to obtain informed consent for personal care and entering rooms.</p> <p>Discussion with relatives confirmed that the service actively involves them in decisions that affect their relative's lives.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Residents interviewed confirmed they are aware of their right to access independent advocacy services. Discussions with relatives confirmed the service provided opportunities for the family/EPOA to be involved in decisions. The chaplain is identified by staff and residents as an advocate. The resident files include information on residents' family/whānau and chosen social networks.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. The activities programme includes opportunities to attend events outside of the facility. Residents are supported and encouraged to remain involved in the community. Relatives and friends are encouraged to be involved with the service and care.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission. Interviews with all residents and relatives confirmed their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints.</p> <p>A complaints register includes written and verbal complaints, dates and actions taken. Complaints are being managed in a timely manner meeting requirements determined by the Health and Disability Commissioner (HDC). There is evidence of lodged complaints being discussed in management and staff meetings. All complaints received have been documented as resolved with appropriate corrective actions implemented.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>There is an information pack given to prospective residents and families that includes information about the Code and the nationwide advocacy service. There is the opportunity to discuss aspects of the Code during the admission process. Residents and relatives interviewed confirmed that information had been provided to them around the Code. Large print posters of the Code and</p>

		advocacy information are displayed throughout the facility. A manager discusses the information pack with residents/relatives on admission. Families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	A tour of the premises confirmed there were areas that support personal privacy for residents. Staff were observed to be respectful of residents' privacy by knocking on doors prior to entering resident rooms. Staff could describe definitions around abuse and neglect that aligned with policy. Residents and relatives interviewed confirmed that staff treat residents with respect. The service has a philosophy that promotes quality of life and involves residents in decisions about their care. Resident preferences are identified during the admission and care planning process and this includes family involvement. Interviews with residents confirmed their values and beliefs were considered. Interviews with caregivers described how choice is incorporated into resident cares.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	The Māori health plan policy for the organisation references local Māori healthcare providers regionally within New Zealand and provides recognition of Māori values and beliefs. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with disability and other community representative groups as requested by the resident/family. Cultural needs are addressed in the care plan. Residents who identify as Māori confirmed that their cultural needs were being met by the service.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	An initial care planning meeting is carried out where the resident, and/or whānau as appropriate, are invited to be involved. Individual beliefs or values are discussed and incorporated into the care plan. Six monthly multidisciplinary team meetings occur to assess if needs are being met and family are invited to attend. Discussions with relatives confirmed that residents' values and beliefs are considered. Residents interviewed confirmed that staff take into account their values and beliefs.
Standard 1.1.7: Discrimination Consumers are free from any	FA	Staff job descriptions include responsibilities. The monthly staff meetings include discussions around professional boundaries and concerns as they arise. Management provided guidelines and examples of mentoring for specific situations. Interviews with the managers and care staff

discrimination, coercion, harassment, sexual, financial, or other exploitation.		confirmed their awareness of professional boundaries.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	<p>Policies and procedures are aligned with current accepted best practice. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff.</p> <p>An annual in-service training programme is implemented as per the training plan with training for registered nurses from the DHB and involvement in the ACE programme for all caregivers. The service benchmarks with other Selwyn Foundation services and uses outcomes to improve resident outcomes. Feedback is provided to staff via the staff/quality meetings.</p> <p>There is a minimum of one registered nurse on each shift and caregivers are described by residents and family as being caring and competent.</p>
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	<p>There is an accident/incident reporting policy to guide staff in their responsibility around open disclosure. Staff are required to record family notification when entering an incident into the system. All nine adverse events reviewed met this requirement. Family members interviewed confirmed they are notified following a change of health status of their family member.</p> <p>There is an interpreter policy in place and contact details of interpreters were available.</p>
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	<p>Selwyn Oaks is a Selwyn Foundation aged care facility located in Auckland. The facility is certified to provide rest home and hospital level care for up to 66 residents. Twenty-four beds are dedicated to rest home level of care and thirty-one to hospital level care. Eleven beds are dual purpose.</p> <p>Sixty-three residents were living at the facility during this audit. All residents were on the Aged Related Care contract (28 rest home level and 35 hospital level).</p> <p>The organisational strategic plan 2013 - 2017 documents organisational goals and these are reflected in the 2016 Selwyn Oaks business plan, which describes the vision, values and objectives of Selwyn Oaks. Annual goals are linked to the business plan and reflect regular reviews via regular meetings.</p> <p>The village manager has aged care management experience. The care home is primarily overseen by the care lead who is a registered nurse with aged care experience and has been in the role for 11 years. She is supported by a senior registered nurse and the group residential care</p>

		<p>manager.</p> <p>The village manager and care lead have maintained at least eight hours of professional development activities related to managing an aged care facility.</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	<p>The care lead covers during the temporary absence of the village manager.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	PA Low	<p>The quality and risk management system is embedded into practice. Discussions with the managers (group residential care manager, village manager and care lead), the GP and staff reflected staff involvement in quality and risk management processes.</p> <p>Resident meetings are monthly. Minutes are maintained but do not always reflect resolution of issues raised. Annual resident and relative surveys are completed with results communicated to residents and staff. Corrective action plans have been developed in response to issues raised in the 2015 survey.</p> <p>The service has standard operating procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The service's standard operating procedures are reviewed at a national level by the clinical governance group with input from facility staff every two years. Clinical guidelines are in place to assist care staff. Updates to standard operating procedures included procedures around the implementation of interRAI.</p> <p>The quality monitoring programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation. There are clear guidelines and templates for reporting. The facility has implemented established processes to collect, analyse and evaluate data, which is utilised for service improvements. Key performance areas are benchmarked against other Selwyn facilities. Quality improvement plans (QIP's) which are monitored for implementation by head office are developed when service shortfalls are identified. Results are communicated to staff at staff/quality meetings as reported by staff and management but this is not always documented and meeting minutes did not reflect actions being</p>

		<p>implemented and signed off when completed.</p> <p>Health and safety policies are implemented and monitored by the health and safety committee. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made.</p> <p>Falls prevention strategies are in place including (but not limited to): sensor mats, increased monitoring, identification and meeting of individual needs and mattress perimeter guards.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>There is an incident/accident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise and debriefing. Individual incident/accident reports are completed for each incident/accident with immediate action noted and any follow up action required.</p> <p>A review of nine incident/accident forms (a sample from five resident files) identified that forms are fully completed and include follow up by a registered nurse. Neurological observations are completed for any suspected injury to the head. The care lead is involved in the adverse event process. There is a debriefing process for all critical incidents that includes a staff debrief and a review of the incident at the clinical governance group.</p> <p>The group residential care manager was able to identify situations that would be reported to statutory authorities including (but not limited to): infectious diseases, serious accidents and unexpected death. Five section 31 notifications have been made in 2015 and 2016 to date for fractures (all fractures are reported to the DHB and HealthCERT) and one notification was made around a van accident in 2015.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Human resources policies include recruitment, selection, orientation and staff training and development. Seven staff files reviewed (two registered nurses, a cleaner, the activities coordinator and three caregivers) included a comprehensive recruitment process of reference checking, signed employment contracts and job descriptions, completed orientation programmes and annual performance appraisals.</p> <p>A copy of registered nursing staff and other health practitioner practising certificates is maintained.</p> <p>The orientation programme provides new staff with relevant information for safe work practice. There is an implemented annual education and training plan that exceeds eight hours annually.</p>

		<p>The training plan is implemented using a 'train the trainer' model where key staff are trained to provide education sessions on subjects that cover a number of required trainings. Aspects of training are provided during full day training sessions. Incidental training is provided according to identified need and at staff request. There is an attendance register for each training session and an individual staff member record of training.</p> <p>Registered nurses are supported to maintain their professional competency. There are implemented competencies for registered nurses including (but not limited to): medication competencies, restraint competencies, controlled drug competencies and insulin competencies.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>A policy is in place for determining staffing levels and skills mix for safe service delivery. Rosters implement the staffing rationale. There are three registered nurses on morning shift, two on afternoon shift and one on night shift. A registered nurse from the management team is on call at all times. Activities are provided five days a week.</p> <p>Staff working on the days of the audit were visible and were attending to call bells in a timely manner as confirmed by all residents interviewed. Staff interviewed stated that overall the staffing levels are satisfactory and that the managers provide good support. Residents and family members interviewed report there are sufficient staff numbers.</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>	PA Low	<p>The resident files were appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Information containing personal resident information is not always kept confidential and at times could be viewed by other residents or members of the public. Resident files are protected from unauthorised access. Entries are legible, dated and signed by the relevant caregiver or nurse including designation. Individual resident files demonstrate service integration.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>There are policies and procedures in place around entry to services. The service provides an information pack on entry to services.</p> <p>Registered nurses assess all residents on entry to service and information gained is included in the resident records. Registered nurses interviewed were able to describe the entry and admission process. The GP is notified of new admissions.</p> <p>Eight signed admission agreements were sighted and all had been signed. The agreement aligns</p>

		to the service contracts and exclusions from the service are included in the admission agreement.
<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>	FA	<p>The service has transfer/discharge/exit policy and procedures in place. The procedures include a transfer/discharge form and 'the yellow envelope' is used. The RNs report that they include copies of all the required information in the envelope.</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>	FA	<p>There are comprehensive policies and procedures (standard operating procedures) in place for all aspects of medication management, including self-administration. The RN's check all medications on delivery against the medication and any pharmacy errors are recorded and fed back to the supplying pharmacy.</p> <p>Registered nurses are responsible for the administering of medications and have completed annual medication competencies and annual medication education. Caregivers who act as a second checker also complete a medication competency. There were two self-medicating rest home residents on the day of audit. Self-medicating competency, three monthly reviews and monitoring was in place. The medication fridge has temperatures recorded daily and these are within acceptable ranges.</p> <p>The medication room was clean and well organised, all medications were in date and stored appropriately</p> <p>Eighteen medication charts were reviewed. Photo identification and allergy status was evident on all charts. All medication charts had been reviewed by the GP at least three monthly. All resident medication administration signing sheets corresponded with the medication chart.</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>	FA	<p>The residents' individual food, fluids and nutritional needs were met. Residents are provided with a balanced diet, which meets their cultural and nutritional requirements. The food service is contracted to an external provider. The meals are cooked on-site.</p> <p>The external contractor has a summer and winter menu reviewed by a registered dietitian as per the contract and they also provide dietetic input into the provision of special menus and diets where required. A dietary assessment is completed on all residents at the time they are admitted. Residents with special dietary needs have these needs identified. Resource information on these diets is available in the kitchen and via the dietitian. Resident forums discuss food and feedback</p>

		<p>is given.</p> <p>Residents interviewed praised the meals.</p> <p>Special equipment is available such as lipped plates/assist cups/grip and built up spoons and on observing mealtimes, it was noted there were sufficient staff to assist residents.</p> <p>The kitchen was observed to be clean and well organised and all aspects of food procurement, production, preparation, storage, delivery and disposal complied with current legislation and guidelines.</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>	FA	<p>The reason for declining service entry to residents to the service is recorded and should this occur, the service stated it would be communicated to the resident/family and the appropriate referrer. Potential residents would only be declined if there were no beds available or they did not meet the service requirements.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	PA Low	<p>The RNs complete a variety of assessment tools on admission along with an interRAI assessment. Assessments reviewed included falls, pressure risk, dietary needs, continence, pain, mobility, cognitive and depression. All resident files sampled had an interRAI assessment but two had conflicting information within the assessment. The outcomes of these assessments were not always reflected in long-term care plans reviewed (link to 1.3.5.2).</p> <p>Pain assessments were evidenced as completed with ongoing monitoring recorded, for residents requiring administration of controlled medication as part of prescribed pain management plan.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	PA Moderate	<p>The long-term care plans reviewed were resident focused, integrated and promoted continuity of service delivery. Not all long-term care plans documented all required resident needs. The facility uses an integrated document system where the GP, nurse practitioner, allied services, the RNs, occupational therapist, activities assistant, physiotherapist and other visiting health providers write their care notes in the resident file.</p> <p>All resident care plans were resident focused. Family members interviewed agreed that they had been involved in the care planning development and review process. Short-term care plans were in place for acute and short term conditions and had been evaluated on a regular basis.</p>

<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Low</p>	<p>All resident files reviewed had nursing and lifestyle care plans in place (link 1.3.5.2). When a resident's condition changes, the RN initiates a GP/NP visit or nursing specialist referral. Residents interviewed reported their needs were being met. Family members interviewed stated the care and support met their expectations for their relative. There was documented evidence of relative contact for any changes to resident health status.</p> <p>Continence products are available and resident files include a three-day urinary continence assessment, bowel management and continence products identified for day use, night use and other management. Specialist continence advice is available as needed and this could be described by the RNs interviewed. Caregivers and RNs interviewed state there is adequate continence and wound care supplies.</p> <p>Wound care plans included an assessment, wound management and evaluation forms and a short-term care plan. Six wounds were documented on the day of audit; five skin tears (all rest home level) and one blister (hospital level). There were no pressure injuries.</p> <p>Monitoring charts were in use and examples sighted included (but not limited to): weight and vital signs, blood glucose, pain, food and fluid, turning charts and behaviour monitoring as required. However, monitoring and interventions were not always constantly documented.</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 full-time occupational therapist (OT) plus an activities assistant three days a week. Activities are provided five days a week and music recitals, movies and church services are arranged for the weekends. A wide range of activities, addressing the abilities and needs of residents in the hospital and rest home, were offered. Activities included physical, mental, spiritual and social aspects of life to improve and maintain residents' wellbeing. The programme timetable was available to all, along with additional eye catching material promoting specific activities to tempt residents to join in. Selwyn Oaks has implemented evening programmes to support residents with 'sun downing'.</p> <p>The service is active with the Eden philosophy and this was evident through the smaller home-like resident bays. Residents were observed taking part in the day-to-day service (such as assisting with meals and gardening).</p> <p>On admission, an activity coordinator completes an assessment for each resident and an activity plan is completed. A record is kept of individual resident's activities and progress notes completed monthly. Reviews are conducted six monthly (or earlier should the residents condition</p>

		<p>determine) as part of the care plan evaluation/review. The resident/family/EPOA as appropriate is involved in the development of the activity plan.</p> <p>Residents and family interviews confirmed they enjoyed the variety of activities and were satisfied with the activities programme. Activities included outings as well as community involvement. Some of those included in activities offered are Christian groups, trips to local restaurants, pet therapy, musicians, yoga and Tai Chi. There are volunteers that assist with a variety of activities including van outings. The clown doctors' service has recently begun regular visits to the service.</p> <p>Residents and families interviewed confirmed the activity programme was developed around the interest of the residents. A forum is held monthly where residents and relatives have input. Minutes are recorded at the forum, quality improvements identified and feedback given.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The resident files reviewed evidenced that long-term care plans had been reviewed six monthly and were updated when needs changed. Clinical reviews were documented in the multidisciplinary review (MDR) records, which included input from the GP, RNs, OT, activities assistant, physio and resident/family. Progress notes were completed and reflected response to interventions and treatments. Changes to care were documented with exceptions (link 1.3.5.2). Documentation of GP visits were evidence that reviews were occurring at least three monthly. Short-term care plans were in use for short term issues.</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 services (medical and non-medical) and where access occurs, referral documentation is maintained. Residents' and/or their family/whānau are involved as appropriate when referral to another service occurs. Registered nurses interviewed described the referral process should they require assistance from specialist practitioners. The review of resident folders included evidence of recent referrals.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious</p>	FA	<p>The infection control manual contains documented policies and procedures for the safe and appropriate storage and disposal of waste and hazardous substances. The health and safety manual includes policy around safe storage and handling of chemicals. Waste is appropriately managed.</p> <p>Chemicals are secured in designated locked cupboards. Chemicals are labelled and safety data</p>

<p>or hazardous substances, generated during service delivery.</p>		<p>sheets were available throughout the facility and accessible to staff. Chemicals were observed to be secured in sluice room cupboards and the laundry chemical storage room. Safe chemical handling training has been provided. Personal protective equipment/clothing (including disposable gloves, aprons and goggles) was sighted in all high risk areas. Staff were observed wearing disposable gloves and aprons appropriately.</p> <p>Staff interviewed demonstrated knowledge of handling chemicals.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The service displays a current building warrant of fitness. There is a maintenance work notification book for staff to communicate with maintenance staff on issues and areas that requires attention. A preventative maintenance schedule has been commenced for the service. Hot water temperatures are monitored and recorded monthly. Electrical equipment is tested and tagged. All hoists have been checked and serviced and medical equipment has been calibrated and checked. The facility van is registered and each has a current warrant of fitness.</p> <p>Residents were observed moving easily around the building with walking aids, wheelchairs and independently.</p> <p>There are outside courtyard areas with seating, tables and shaded areas that are easily accessible. All hazards have been identified in the hazard register.</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 requirements.</p>	<p>FA</p>	<p>There are sufficient communal showers and communal toilets for residents. Some resident rooms have a full ensuite and some have a toilet and basin. Resident rooms have hand-washing facilities with soap dispensers and paper towels. Communal bathroom and toilet facilities have a system that indicates if it is engaged or vacant. Privacy is further maintained by additional curtains behind doors in some areas.</p>
<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>	<p>FA</p>	<p>Residents rooms are of an adequate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Transfer of residents can occur on an ambulance stretcher and equipment can be transferred between rooms. Mobility aids can be managed in communal bathrooms.</p> <p>Rooms can be personalised with furnishings, photos and other personal adornments and the</p>

		<p>service encouraged residents to make the room their own.</p> <p>There was room to store mobility aids such as walking frames in the bedroom safely during the day and night if required.</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>The service has a number of communal lounge/dining areas. There are smaller seating areas for residents and families around the facility. Furniture in all areas is arranged to allow residents to freely mobilise. Residents and families interviewed agreed that the service is spacious and residents may stay in their own wings or join in any of the communal lounges.</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 provided.</p>	FA	<p>All laundry is completed off-site except some rest home personal laundry items. Residents and relatives expressed satisfaction with cleaning and laundry services. The service has secure cupboards for the storage of cleaning chemicals. Chemicals are labelled. Material safety data sheets are displayed. Cleaning processes are monitored for effectiveness and compliance with the service policies and procedures. Cleaning staff have completed chemical safety training.</p>
<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>There is at least one staff member on duty at all times with a first aid certificate. Emergency preparedness plans are accessible to staff and includes management of all potential emergency situations. The service has implemented policies and procedures for civil defence and other emergencies. The service has civil defence resources and supplies. There are sufficient first aid and dressing supplies available. The service has an approved fire evacuation scheme. Fire evacuation training and drills are conducted six monthly.</p> <p>Emergency equipment, water and food are available</p> <p>Call bells were situated in all communal areas, toilets, bathrooms and personal bedrooms. Residents were sighted to have call bells within reach during the audit. The service has a visitor's book at reception for all visitors including contractors to sign in and out. Appropriate security systems are in place.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p>	FA	<p>Residents are provided with adequate natural light, safe ventilation and an environment that is maintained at a safe and comfortable temperature.</p>

<p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>		
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>Selwyn Oaks has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system and the Selwyn KPI's. A registered nurse is the designated infection control nurse with support from the care lead and all staff through the quality meeting acting as the infection control team. Minutes are available for staff. Audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The Selwyn Foundation infection control programme was last reviewed in September 2015.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>A registered nurse at Selwyn Oaks is the designated infection control (IC) nurse. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse and IC team (comprising all staff) has good external support from the local laboratory infection control team and IC nurse specialist at the DHB. The infection control team is representative of the facility. Infection prevention and control is 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 provided.</p>	<p>FA</p>	<p>The Selwyn Foundation infection control policies and procedures are appropriate for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies were developed by the Selwyn clinical governance and have been reviewed and updated.</p>

<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred. The infection control nurse has completed infection control training through the Selwyn infection control coordinators bi-annual meeting/training days. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.</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>	<p>FA</p>	<p>Infection surveillance is an integral part of the infection control programme and is described in Selwyn's infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. Short-term care plans are used. Surveillance of all infections is entered on to a monthly infection summary. This data is monitored and evaluated monthly and annually and provided to Selwyn head office for benchmarking. Infections are part of the key performance indicators. Outcomes and actions are discussed at quality/staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the care lead. There have been no outbreaks since the previous audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. Restraint minimisation policies and procedures are comprehensive and include definitions, processes and use of restraints and enablers.</p> <p>There was one resident using an enabler (a lap belt) and no residents with restraints during the audit. The resident had signed consent for the use of the enabler.</p> <p>Staff training is in place around restraint minimisation and enablers, falls prevention and management of challenging behaviours.</p>

Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	The service holds monthly resident meetings, monthly combined quality and staff meetings and monthly registered nurse forums. Minutes are kept for all meetings. Staff and residents interviewed report issues raised are followed up. Staff and management reported quality data trends including infection control, incidents, audit outcomes and complaints are discussed in meetings. Meeting minutes do not always reflect resolution of issues raised or discussions around trend analysis outcomes.	Resident and staff/quality meeting minutes do not document resolution of issues raised. Staff/quality meeting minutes do not document discussion around trend analysis outcomes for infections and incidents and RN forum meeting minutes do not document discussion around incident trend analysis outcomes.	Ensure that resolution of issues raised and outcomes of quality data analysis are discussed and documented for meetings. 90 days

<p>Criterion 1.2.9.7 Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.</p>	<p>PA Low</p>	<p>Resident's main files are kept in the nurse's office, which is locked when not attended and no whiteboards or similar containing resident information could be viewed. There is a caregiver folder, which contains the care plan summary for the residents in each wing, which is kept in each wing. These were not locked away when not being used in some wings.</p>	<p>During the audit, three caregiver folders containing confidential resident information were sighted being left in places where visitors or residents could access them.</p>	<p>Ensure all confidential resident information is not publically accessible.</p> <p>90 days</p>
<p>Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA Low</p>	<p>On admission to services, RNs undertake a wide range of paper based assessments, such as pain, Waterlow, continence and falls. From the sample of files reviewed, three rest home residents had been admitted since June 2015. One rest home resident had an interRAI assessment completed within 21 days and one rest home resident had a long-term care plan completed within 21 days. All residents (rest home and hospital) who had been in the service for over six months had six monthly care plan reviews and MDT documented.</p>	<p>Two rest home residents did not have an interRAI assessment or a long-term care plan completed within 21 days of admission. Both had an interRAI assessment and long-term care plan completed at the time of audit.</p>	<p>Ensure that the initial interRAI is documented within three weeks of admission and that the long-term care plan is documented within three weeks of admission.</p> <p>60 days</p>
<p>Criterion 1.3.4.2 The needs, outcomes, and/or goals of consumers are identified via the assessment process and are</p>	<p>PA Low</p>	<p>The service is embedding the use of interRAI for both initial assessments and for ongoing re-assessment and MDT/care plan reviews. Paper based assessments continue to be undertaken to assist the care planning process. Six of eight interRAI assessments sampled reflected resident's needs.</p>	<p>Two interRAI assessments (one hospital and one rest home) contained contradictory information.</p>	<p>Ensure that the assessment process is consistent and appropriate to the needs of</p>

documented to serve as the basis for service delivery planning.				the resident. 60 days
Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	PA Moderate	All residents had a nursing care plan, as well as a lifestyle care plan summary however, not all care plans reflected all resident needs. The summary care plans are intended for caregivers to follow when providing resident cares. Care staff interviewed stated they have access to both care plans as needed. Staff interviewed were aware of the interventions needed.	For the rest home level care plans: one resident on insulin did not have the recognition and treatment for hypoglycaemia documented in the lifestyle care plan; one resident with re-occurring nose bleeds did not have the interventions needed in the event of a nose bleed documented in the lifestyle care plan; and one resident with behaviours that challenge did not have interventions documented to manage the behaviour in the lifestyle care plan. For the hospital level care plans: one resident did not have interRAI interventions documented in the care plan(s) (such as safety when toileting and regular toileting), for this same resident the management of pain and the need to encourage fluids were not documented; one resident did not have the risk of choking and interventions documented in the care plan(s); and one resident on insulin did not have the recognition and treatment of hypoglycaemia documented in the lifestyle care plan. The nursing care plans in the hospital and rest home all had evidence of care plan updating, however previous interventions had not always been crossed out.	Ensure that care plans document the support needs to manage resident care requirements. 60 days
Criterion 1.3.6.1 The provision of services and/or	PA Low	Discussion with family members' evidences that the standard of care is high and that staff make all efforts to ensure the safety and comfort of the residents. The GP stated that the standard of care was very	One rest home level resident who required daily weight monitoring did not have this documented; and one hospital level resident who required twice daily walks did not have this intervention	Ensure that all care and support interventions

<p>interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>		<p>good. Monitoring and interventions were not always documented as completed.</p>	<p>documented as occurring.</p>	<p>are undertaken as directed.</p> <p>60 days</p>
---	--	--	---------------------------------	---

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.