# Selwyn Care Limited - Wilson Carlile House

## Introduction

This report records the results of a Certification Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Selwyn Care Limited

**Premises audited:** Wilson Carlile House

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

**Dates of audit:** Start date: 6 April 2016 End date: 7 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:** 56

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

## General overview of the audit

Selwyn Wilson Carlile is owned and operated by the Selwyn Foundation and cares for up to 59 residents requiring rest home or hospital level care. On the day of the audit, there were 56 residents.

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

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

The service has exceeded the standard around weight management, staff education, communication and activities.

This audit has identified areas for improvement around the preventative maintenance programme and restraint monitoring.

## Consumer rights

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

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. |  | Standards applicable to this service fully attained. |

Services are planned, coordinated and are appropriate to the needs of the residents. The village manager is responsible for the day-to-day operations. Goals are documented for the service with evidence of regular reviews. A quality and risk management programme is 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

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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. |  | Standards applicable to this service fully attained. |

Residents are assessed prior to entry to the service. A baseline assessment is completed upon admission and an interRAI assessment within three weeks. Lifestyle support plans are developed by the service’s registered nurses, who also have the responsibility for maintaining and reviewing the support plans.

InterRAI assessment tools and monitoring forms are used to assess the level of risk and ongoing support required for residents. Lifestyle support plans are evaluated six monthly or more frequently when clinically indicated. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files.

The activity programme is varied and reflects the interests of the residents including community interactions.

There are medication management policies that are comprehensive and direct staff in terms of their responsibilities in each stage of medication management. Competencies are completed. Medication profiles are up to date and reviewed by the general practitioner three monthly or earlier if necessary.

The menu is designed and reviewed by a registered dietitian. Residents' individual needs are identified. There is a process in place to ensure changes to residents’ dietary needs are communicated to the kitchen. Regular audits of the kitchen occur.

## Safe and appropriate environment

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

The service displays a current building warrant of fitness. Reactive maintenance is carried out. Furniture and fittings are selected with consideration to residents’ abilities and functioning. Residents can and do bring in their own furnishings for their rooms. The service has policies and procedures for management of waste and hazardous substances and incidents are reported on in a timely manner. Staff 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 undertaken on-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

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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. |  | Some standards applicable to this service partially attained and of low risk. |

Staff regularly receives education and training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. A register is maintained by the restraint coordinator. During the audit, five residents were using restraints and no residents were using enablers.

## 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. |

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

## Summary of attainment

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 1 | 47 | 0 | 2 | 0 | 0 | 0 |
| **Criteria** | 3 | 96 | 0 | 2 | 0 | 0 | 0 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Unattained Negligible Risk**  **(UA Negligible)** | **Unattained Low Risk**  **(UA Low)** | **Unattained Moderate Risk**  **(UA Moderate)** | **Unattained High Risk**  **(UA High)** | **Unattained Critical Risk**  **(UA Critical)** |
| **Standards** | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 |

# Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

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

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | Selwyn Wilson Carlile’s 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 (five caregivers, two registered nurses (RNs) and one diversional therapist) confirmed their understanding of the Code. Twelve residents (seven rest home level and five hospital level) and seven relatives (three hospital level and four rest home level) interviewed confirmed that staff respect privacy and support residents in making choices. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | The service has policies and procedures relating to informed consent and advanced directives. All eight resident files reviewed included signed informed consent forms and advanced directive instructions. Staff are aware of advanced directives. Admission agreements were sighted which were signed by the resident or nominated representative. Discussion with residents and families identified that the service actively involves them in decision making. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Residents interviewed 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. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | Residents and relatives interviewed 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. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The service has a complaints policy that describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission. Interviews with all residents and relatives confirmed their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints.  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. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | There is an information pack given to prospective residents and families that includes information about the Code and the nationwide advocacy service. There is the opportunity to discuss aspects of the Code during the admission process. Residents and relatives interviewed confirmed that information had been provided to them around the Code. Large print posters of the Code and advocacy information are displayed throughout the facility. A manager discusses the information pack with residents/relatives on admission. Families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | A tour of the premises confirmed there 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. An annual resident satisfaction survey was completed in July 2015 and the results showed that overall resident experience was reported as being good or very good by the majority of respondents. 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 identified as Māori confirmed their cultural needs were being met by the service. In 2015, the service held a Māori cultural week and a marae visit was arranged. |
| 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. 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 discrimination, coercion, harassment, sexual, financial, or other exploitation. | 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 confirmed their awareness of professional boundaries. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | 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.  An annual in-service training programme is implemented as per the training plan. Registered nurses are able to attend DHB training and caregivers are provided with a training programme. The service benchmarks with other Selwyn Foundation services and uses outcomes to improve resident outcomes. Feedback is provided to staff via the staff/quality meetings  There is a minimum of one registered nurse on each shift and caregivers are described by residents and family as being caring and competent. A number of process improvements have been implemented resulting in improvements to resident wellbeing (link to CI 1.1.9.1, 1.2.7.5 and 1.3.13.1). |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | CI | 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 11 adverse events reviewed met this requirement. Family members interviewed confirmed they are notified following a change of health status of their family member. The service has exceeded the standard around ensuring that all staff are able to communicate effectively with residents.  There is an interpreter policy in place and contact details of interpreters were available. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Selwyn Wilson Carlile is a Selwyn Foundation aged care facility located in Hamilton. The facility is certified to provide rest home and hospital (geriatric and medical) level care for up to 59 residents. Thirty beds are dedicated to rest home level of care and the other 29 are dual purpose beds.  Fifty six residents were living at the facility at the time of audit. One resident was on a post-acute care contract (medical) and all others were on the Aged Related Care contract (35 rest home level and 20 hospital level).  The organisational Strategic plan 2013 to 2017 documents organisational goals and these are reflected in the 2016 Selwyn Wilson Carlile business plan, which describes the vision, values and objectives of Selwyn Wilson Carlile. Annual goals are linked to the business plan and reflect regular reviews via regular meetings.  The Waikato village manager, the assistant village manager and the assistant care lead have aged care management experience. The care home is primarily overseen by the assistant village manager and assistant care lead (both registered nurses with aged care experience who have been in the role for 18 months and nine years respectively). They are supported by the group residential care manager.  The Waikato village manager, assistant village manager and assistant care lead have maintained at least eight hours of professional development activities related to managing an aged care facility. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | The assistant village manager and assistant care lead cover during the temporary absence of one or the other. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | An established quality and risk management system is embedded into practice. Quality and risk performance is reported across facility meetings and to the residential group manager. Discussions with the managers (group residential care manager, Waikato village manager, assistant village manager and assistant care lead), the GP and staff reflected staff involvement in quality and risk management processes.  Resident meetings are monthly. Minutes are maintained. Annual resident and relative surveys are completed with results communicated to residents and staff. Survey results reflect high levels of satisfaction.  The service has policies, procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The service's policies are reviewed at a national level by the clinical governance group with input from facility staff every two years. Standard Operating Procedures (SOP’s) are in place to assist care staff. Updates to SOP’s included procedures around the implementation of interRAI.  The quality monitoring programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation. There are clear guidelines and templates for reporting. The facility has implemented established processes to collect, analyse and evaluate data, which is utilised for service improvements. Key performance areas are benchmarked against other similar facilities. Quality improvement plans (QIP’s) are developed when service shortfalls are identified and these are monitored by head office. Results are communicated to staff at staff/quality meetings and reflected actions are being implemented and signed off when completed.  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.  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. |
| 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 | There is an incident/accident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise and debriefing. Individual incident/accident reports are completed for each incident/accident with immediate action noted and any follow up action required.  A review of 11 incident/accident forms (a sample from February and March 2016) 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 Waikato village manager, assistant care lead and assistant village manager are involved in the adverse event process. There is a debriefing process for all critical incidents that includes a staff debrief and a review of the incident at the clinical governance group.  The group residential care manager was able to identify situations that would be reported to statutory authorities including (but not limited to): infectious diseases, serious accidents and unexpected death. Appropriate notification had been made regarding eight fractures and six other incidents including two sudden deaths (one of which is still the subject of a coronial inquiry). A review of falls involving fractures (all eight were reviewed showed that there were no trends such as staffing levels, times of day, certain areas of the facility or similar, able to be identified) demonstrated that all had a full critical event procedure followed. The service reports every fracture to the DHB and HealthCERT. An outbreak in March 2015 was notified appropriately. |
| 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 | Human resources policies include recruitment, selection, orientation and staff training and development. Six staff files reviewed (the assistant care lead, one other registered nurse, the chef manager, the diversional therapist and two caregivers) included a comprehensive recruitment process which included reference checking, signed employment contracts and job descriptions, completed orientation programmes and annual performance appraisals.  A register of registered nursing staff and other health practitioner practising certificates is maintained.  The orientation programme provides new staff with relevant information for safe work practice. There is an implemented annual education and training plan that exceeds eight hours annually. The training plan is implemented using a ‘train the trainer’ model where key staff are trained to provide education sessions on subjects that cover a number of required trainings. Aspects of training are provided during full day training sessions. 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. The service has exceeded the required standard around training provided to staff improving outcomes for residents.  Registered nurses are supported to maintain their professional competency. Four of the six permanent registered nurses have completed their interRAI training. There are implemented competencies for registered nurses. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | A policy is in place for determining staffing levels and skills mix for safe service delivery. In addition to the registered nurses on the management team, there is a registered nurse on duty 24 hours per day and one day per week (eight hours) is covered with another registered nurse. A registered nurse from the management team is on call at all times. Activities are provided five days a week.  Staff were visible and were attending to call bells in a timely manner as confirmed by all residents interviewed. Staff interviewed stated that overall the staffing levels are satisfactory and that the managers provide good support. Residents and family members interviewed report there are sufficient staff numbers. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident files 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 kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access. Entries are legible, dated and signed by the relevant caregiver or nurse including designation. Individual resident files demonstrate service integration. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | All residents are assessed prior to entry for rest home or hospital level of care. The service has specific information available for residents/families/whānau at entry and it includes associated information such as the Code of Rights, advocacy and the complaints procedure.  There is a comprehensive admission booklet available to all residents/family/whānau on enquiry or admission the information includes examples of how services can be accessed that are not included in the agreement. Registered nurses interviewed were able to describe the entry and admission process. The GP is notified of a new admission.  Eight signed admission agreements were sighted. The admission agreement reviewed aligns with a) – k) of the Aged Residential Care Contract. Exclusions from the service are included in the admission agreement. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | The service has transfer/discharge/exit policy and procedures in place. The procedures include a transfer/discharge form. The RNs report that they include copies of all the required information, medications and belongings. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | Medicine management policies and procedures are in place and implemented. They follow recognised standards and guidelines for safe medicine management practice in accordance with the guideline: medicines care guides for aged residential care. Medicines are stored securely in each of the three rest home villas and the hospital unit. Medication fridge temperatures met requirements. Unwanted or expired medications are collected by the pharmacy weekly. Medicines (robotic rolls) are delivered monthly by the pharmacy and checked by an RN on-site. An RN does a weekly check for expired medication. All eye drops were noted to be dated at opening. No expired medications were noted on any trolleys or medication storage shelves. Bulk supply was used for some medicines in the hospital only.  A medication round was observed; the procedure followed by the registered nurse was correct and safe. The service uses a paper based medication administration system.  Registered nurses administer medications to hospital residents. Carers complete competency for second checking only. Carers in the rest home have medicine competency and administer medicines. Sixteen medication charts were sampled. All had photo identification, allergies noted and the medication charts were clear with directions for medication use and correctly signed and dated discontinuation of medications.  The self-medicating policy includes procedures on the safe administration of medicines. Three residents were self- medicating. The residents self-medicating competency is reviewed three monthly. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The residents’ individual food, fluids and nutritional needs were met. Residents are provided with a balanced diet, which meets their cultural and nutritional requirements. The meals are cooked on-site. The kitchen also provides meals to another facility. Food is sent to the individual unit servery’s in bain Maries. Food temperatures are recorded when food is placed in bain maries and on exit from kitchen. Fridge temperatures are recorded for the fridge in each servery.  There is a summer and winter menu that has been reviewed by a registered dietitian who also provides dietetic input around 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 weight loss are reviewed and dietary modifications made as required. Residents with special dietary needs have these needs identified. Resource information on these diets is available in the kitchen. The service has exceeded the required standard around the management of residents with weight loss.  A dietary assessment for each resident is sent to the kitchen alerting the chef of any special requirements likes and dislikes, or meal texture required. Feedback on satisfaction with meals is obtained from residents. Corrective actions are undertaken if required.  Special equipment is available and on observing mealtimes, it was noted there were sufficient staff to assist residents.  A kitchen cleaning schedule was in place and implemented. The chiller, fridge and freezer temperatures were monitored. 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. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | 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/whānau and the appropriate referrer. Potential residents would only be declined if there were no beds available or they did not meet the service requirements. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | The resident’s needs, support requirements and preferences were collected and recorded within required timeframes. The RNs complete a variety of assessment tools on admission along with a long term interRAI assessment. Four RNs are interRAI trained. Assessments reviewed included falls, pressure risk, dietary needs, continence, pain, mobility, cognitive and depression. All residents have a long term interRAI assessment. The outcomes of these assessments were reflected in all long-term care plans reviewed.  Each resident is allocated a primary nurse. A schedule is maintained of assessments and reviews with responsibilities clearly allocated. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The long-term care plans reviewed were resident focused, integrated and promoted continuity of service delivery. An initial plan of care was developed on admission while the long-term plans were developed within 21 days of admission. The facility uses an integrated document system where the general practitioner, allied services, the RNs, diversional therapist, physiotherapist and other visiting health providers write their care notes.  The resident files had sections for the resident’s profile, details, observations, long-term care plans, monitoring and risk assessments. Interventions sighted were consistent with the assessed needs and best practice. Goals were realistic, achievable and clearly documented. The service recorded intervention for the achievement of the goals. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Residents received adequate and appropriate services meeting their assessed needs and desired outcomes. Interventions were documented for each goal in the long-term care plans. Interventions from allied health providers were included in the long-term care plan and where appropriate in a short-term plan.  Residents and family involvement in the development of and review of care plans was encouraged. Evidence of communication and of multidisciplinary reviews was viewed in clinical notes.  Dressing supplies and continence products are readily available. Registered nurses interviewed were able to describe access to specialist services if required.  Wound assessment and wound management plans are in place for six residents with wounds: one skin tear, one broken haematoma, six chronic ulcers and a grade II pressure injury (two residents had more than one wound). All wounds have documented assessments and a treatment plan in place. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The activity programme confirmed that independence was encouraged and choices were offered to residents. The full-time diversional therapist and one assistant (eight hours a week) coordinate the programme. A wide range of activities, addressing the abilities and needs of residents in the hospital and rest home, were offered. There was also a regular volunteer for two days a week. Another volunteer has been added for two days a week. This has resulted in a wider range of activities being available to residents.  A room is dedicated to activities and includes a bowling table, tables and a kitchenette. Gardens are available for residents to use, along with a range of resource materials accessible for the staff to utilise. A van is available for outings. Activities included physical, mental, spiritual and social aspects of life to improve and maintain residents’ wellbeing. During the on-site visit, a number of activities were evident including craft, exercise, an outing and a new ‘By Invitation’ innovation, which was asking a small number of residents reluctant to join in larger groups to attend a small group activity. Participation in the activities included care staff.  On admission, the diversional therapist 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 resident’s condition determine) as part of the care plan evaluation/review. The resident and family (where possible), is involved in the development of the activity plan. Activities are personalised and meaningful to the residents.  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. In 2015, there was a year of making crafts for a community Advent Fair. Residents took ownership of it and raised money, which they donated to charity. A recent activity was a Māori themed week which included a marae visit and a group visiting the home to speak Māori (a resident in the home speaks Māori) and to undertake flax weaving with the residents.  The diversional therapist and assistant have current first aid certificates.  Residents interviewed confirmed the activity programme was developed around their interests. Monthly resident meetings are held where residents and relatives have input. Minutes are recorded and changes are made to reflect the activities the residents want. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Long-term care plans have been reviewed six monthly and updated when needs changed. Clinical reviews were documented in the multidisciplinary review. The reviews included input from the GP, RNs, diversional therapist, physiotherapist and resident/family. Progress notes were completed and reflected response to interventions and treatments. Changes to care were documented. Documentation of GP visits were evidence that reviews were occurring at least three monthly. Additional reviews included the three monthly medication reviews by the GP. Short-term care plans were in use for short term issues. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | 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 a wound specialist, physiotherapist and dietitian. The review of resident files included evidence of recent referrals. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | The service has documented policies and procedures for the safe and appropriate storage and disposal of waste and hazardous substances. Waste is appropriately managed.  Chemicals are secured in designated locked cupboards. Chemicals are labelled and safety data sheets were available throughout the facility and accessible to staff. Chemicals were observed to be safely secured, this included security whilst being used when cleaning- there is a locked cupboard on the cleaning trolley. Safe chemical handling training has been provided. Personal protective equipment/clothing was sighted in all high risk areas. Staff were observed wearing disposable gloves and aprons appropriately.  Staff questioned demonstrated knowledge of handling chemicals. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | PA Low | The service displays a current building warrant of fitness. There is a maintenance work notification book for staff to communicate with maintenance staff about issues and areas that requires attention. Preventative maintenance is not fully documented. Hot water temperatures are monitored and recorded monthly. There is maintenance person who also covers other facilities and a maintenance/gardener person who is based on-site. Electrical equipment has been tested and tagged. All hoists have been checked and serviced (May 2015) and medical equipment has been calibrated and checked (due May 16). The facility van is registered and has a current warrant of fitness.  There are outside areas with seating, tables and shaded areas that are easily accessible. Pathways, seating and grounds appear well maintained. All hazards have been identified in the hazard register. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | There are sufficient communal showers and communal toilets for residents. Some resident rooms have a full ensuite (twenty in hospital) 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. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | 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 between rooms. Mobility aids can be managed in communal bathrooms.  Rooms are personalised with furnishings, photos and other personal adornments and the service encourages residents to make the room their own.  There was room to store mobility aids such as walking frames in the bedroom safely during the day and night if required. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | The rest home area is divided into three ‘villas’, each having their own lounge, dining and kitchenette so a more home-like environment is created. There is also a large dining room and lounge and a very spacious activities room. There are smaller seating areas for residents and families around the facility. Furniture in all areas is arranged to allow residents to freely mobilise. Activities can occur in many areas including the courtyards. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | Laundry is completed on-site with an appropriate separation of clean and dirty laundry. Residents and relatives expressed satisfaction with cleaning and laundry services. The service has secure cupboards for the storage of cleaning chemicals. Chemicals are labelled. Material safety data sheets are displayed. Cleaning processes are monitored for effectiveness and compliance with the service’s policies and procedures. Cleaning staff have completed chemical safety training. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | There is at least one staff member on duty at all times with a first aid certificate. All registered nurses have current first aid certificates. Emergency preparedness plans are accessible to staff and include management of all potential emergency situations. The service has implemented policies and procedures for civil defence and other emergencies. The service has civil defence resources and supplies. 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.  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. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | Selwyn Wilson Carlile 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. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | A registered nurse at Selwyn Wilson Carlile 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. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | There are Selwyn Foundation infection control policies and procedures appropriate to for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies were developed by the Selwyn clinical governance and have been reviewed and updated. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred. The infection control nurse has completed infection control training through the Selwyn infection control coordinators bi-annual meeting/training days. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Infection surveillance is an integral part of the infection control programme and is described in Selwyn’s infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. Short-term care plans are used. Surveillance of all infections is entered on to a monthly infection summary. This data is monitored and evaluated monthly and annually and provided to Selwyn head office for benchmarking. Infections are part of the key performance indicators. Outcomes and actions are discussed at quality/staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible. An outbreak in March 2015 was appropriately managed. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. Restraint minimisation policies and procedures are comprehensive and include definitions, processes and use of restraints and enablers.  There were no residents using enablers and five hospital residents with restraints (four bedrails, one brief restraint and one lap belt) during the audit.  Staff training is in place around restraint minimisation and enablers, falls prevention and management of challenging behaviours. |
| Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | FA | The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator (a registered nurse) and for staff are documented and understood. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | A restraint assessment tool is completed for residents requiring an approved restraint for safety. Assessments are undertaken by the restraint coordinator in partnership with the RNs, GP, resident and their family/whānau. Restraint assessments are based on information in the care plan, resident/family discussions and observations.  Ongoing consultation with the resident and family/whānau are evident. Three hospital level residents’ files where four restraints were in use (lap belt, brief restraint and bedrails) were selected for review. The completed assessment considered those listed in 2.2.2.1 (a) - (h). |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | PA Low | Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint.  Restraint authorisation is in consultation/partnership with the resident, family and the GP. The use of restraint is linked to the residents’ care plans. Internal restraint audits measure staff compliance in following restraint procedures. Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Monitoring was not consistently documented on four restraint monitoring records reviewed.  A restraint register is in place providing an auditable record of restraint use and is completed for all residents requiring restraints and enablers. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations are conducted monthly and restraint use is discussed monthly at both registered nurse and staff/quality meetings. A review of three resident files identified that evaluations are up to date. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | The restraint minimisation programme is discussed and reviewed at the six monthly organisation-wide restraint coordinators meetings, monthly registered nurse meetings and monthly staff/quality meetings. Meeting minutes include (but are not limited to): a review of the residents using restraints or enablers, updates (if any) to the restraint programme and staff education and training. |

# Specific results for criterion where corrective actions are required

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

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

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.4.2.4  The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group. | PA Low | There is a full-time maintenance person covering three sites. He is supported on this site by a gardener/maintenance person. They undertake reactive maintenance when it is identified as required. A reporting system is in place and evidence shows that items identified are addressed.  Scheduled and planned maintenance covering all aspects of the facility and equipment is not implemented or documented. | There is no documented evidence of a scheduled preventative maintenance plan being implemented. | Ensure that a programme of scheduled maintenance is undertaken for all aspects of building and equipment.  90 days |
| Criterion 2.2.3.4  Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to: (a) Details of the reasons for initiating the restraint, including the desired outcome; (b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint; (c) Details of any advocacy/support offered, provided or facilitated; (d) The outcome of the restraint; (e) Any injury to any person as a result of the use of restraint; (f) Observations and monitoring of the consumer during the restraint; (g) Comments resulting from the evaluation of the restraint. | PA Low | The required frequency of both checking restraints and documenting monitoring was recorded on the care plan and the restraint assessment for each of the four restraints sampled (there are two sets of documentation for one resident with two types of restraint). Staff interviewed (registered nurses and caregivers) and two families of residents with restraints reported that monitoring occurs at least within required times and often with more frequency than the required timeframes. However, this is not always documented. The risk rating is considered low as the issue is documentation related. | Four of four restraint monitoring records sampled had times when monitoring had not been documented at the required frequency. | Ensure restraint monitored is documented as occurring within the documented timeframes.  90 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 1.1.9.1  Consumers have a right to full and frank information and open disclosure from service providers. | CI | Selwyn Foundation (including Wilson Carlile) has an ethos of open communication. They expect that all staff from domestic staff to management will communicate effectively with residents. This has traditionally been difficult due to the high number of staff for whom English is a second language working at this service. Specific training has been provided around business communication to address this. | In November 2013, the Selwyn Foundation identified from resident and family feedback that not all staff were able to communicate information in a way the residents and families deemed of a high standard. They identified that low numeracy and literacy levels among staff were contributing to this and developed a strategy to improve numeracy and literacy skills for staff, to enhance their work communication skills and to enhance the lives of staff.  In 2014 a pilot ‘business communications’ course was run (the course is a two-hour class over 20 weeks) and following the pilot, the programme was adopted with two programmes running during 2015 with courses specifically also run in the Waikato (where Wilson Carlile is based). Eight Wilson Carlile staff has graduated from the course.  The improved communication skills have resulted in increased satisfaction ratings in resident and family surveys in the areas of courtesy/friendliness of care assistants, care assistants treat with care and respect, nurses treat with care, respect, courtliness and friendliness towards visitors by the nurses. Residents confirmed on interview that these improvements have made a difference in their lives. |
| Criterion 1.2.7.5  A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | CI | In 2014, Selwyn improved the methods to deliver staff training and all staff are now trained using modules. The health, safety and wellbeing module covers safety in the workplace, hazard management, risk management, incident reporting, fire and emergency procedures, moving and handling, management of waste and hazardous substances, wellbeing, bullying and harassment and managing stress for wellness. The person centred care module includes the Selwyn Foundation mission, person centred care, the Eden alternative, Code of Rights, abuse and neglect, advocacy, culturally safe care, sexuality and intimacy, care planning, maximising independence, privacy and dignity and death and dying. The clinical care module covers resuscitation, continence, pain management, skin integrity and wound management, nutrition and hydration, dementia and challenging behaviours and palliative care. The communication and documentation in practice module covers communication, listening skills, documentation, clinical records, principles of clinical documentation – paper based and computerised, messages, incident reporting, hazard reporting, complaints and compliments and responding to feedback and privacy and confidentiality. | Selwyn Foundation has reviewed and changed the ways in which training was delivered in 2014 and 2015. The organisation identified in early 2014 that while staff were attending all mandatory training days, they did not all appear to be implementing the material taught. Investigation into this showed that many staff struggled to learn in large groups.  In response to this, core training is now delivered over four modules using a ‘train the trainer’ method. A trainer’s guide, handouts and questionnaires have been developed for each module and Wilson Carlile management or staff has been trained to deliver each module. Each of the modules has been delivered in small groups of four or five staff. Staff interviewed report that they find the new training methods more informative and personalised to their learning style.  Following the introduction of the changed training methods, there has been significant gains in the Selwyn Wilson Carlile satisfaction survey results in questions including technical skills of caregivers and technical skills of nurses. |
| Criterion 1.3.13.1  Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group. | CI | All meals are overseen by the chef manager who is employed at Wilson Carlile – all meals are cooked on-site. The menu is reviewed by a dietitian frequently. The chef manager reported being kept well informed of residents changing dietary needs and this was confirmed by residents and family members interviewed. | Selwyn Wilson Carlile has introduced a range of measures to manage resident’s weight loss with improved outcomes for residents and has exceeded the standard in this area. In September 2015, the service identified that they would like to improve the outcomes for a group of residents with identified weight loss. A number of interventions were implemented.  Short-term care plans for these residents were introduced that included areas such as dysphasia, oral care and other relevant issues. The food choices of these residents were reviewed including likes and dislikes, the cognitive status of the resident and the time of day at which the resident was most awake to eat meals individually. Monthly routine weights continued to capture residents at risk of weight loss and when weight loss is identified, the weight management procedure was followed. Further staff training around weight management was provided in August 2015 for both caregivers and registered nurses.  In April 2016, the programme was reviewed and the four residents on the programme were shown to have gained weight since the programme was introduced. |

End of the report.