Selwyn Care Limited - Brian Wells Lodge

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Selwyn Care Limited
Premises audited:	Brian Wells Lodge
Services audited:	Dementia care
Dates of audit:	Start date: 18 May 2017 End date: 19 May 2017

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 16

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

Brian Wells is owned and operated by the Selwyn Foundation and provides care for up to 16 residents requiring rest home (dementia) level care. On the day of the audit there were 16 residents.

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

The assistant village manager and assistant care lead are well qualified and experienced for the roles. Relatives interviewed spoke positively about the service provided. The service continues to maintain a quality and risk management programme.

The previous audit had no areas for improvement identified. This audit has identified two areas for improvement around medication management and care plan documentation. The service has continued to maintain a continuous improvement rating around incident management.

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.

Information about the Code and services is easily accessible to residents and families. Relatives are involved in the resident's care plans and attend family meetings. Families receive newsletters and stated the service operate an open-door policy. There is a policy in place for the management of complaints and concerns. There have been no complaints.

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.

Brian Wells has a quality and risk management system in place that is implemented and monitored, which generates improvements in practice and service delivery. Key components of the quality management system are discussed with staff as evidenced in meeting minutes. The service is active in analysing data and are benchmarked against other Selwyn facilities. Corrective actions are identified and implemented. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and appropriately managed. There is a comprehensive orientation programme that provides new staff with relevant and specific information for safe work practice. The in-service education programme covers relevant aspects of care and support. The staffing levels provide sufficient and appropriate coverage for the effective delivery of care and support.

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.

Assessments, care plans and evaluations are completed by the registered nurses within the required timeframes. Relatives/whānau are involved in planning and evaluating care. Service delivery plans demonstrate service integration. Care plans are evaluated six-monthly or more frequently when clinically indicated. Short-term care plans are available for use for short term needs. The general practitioner reviews the residents at least three-monthly.

The Selwyn diversional therapist oversees the programme. The programme focused on meaningful activities that meets the individual abilities and recreational preferences. The individual care plans include activities over a 24-hour period. There is an activity coordinator who is supported by caregivers, who also provide activities for the residents.

The service medication management policies and procedures follow recognised standards and guidelines for safe medicine management practice. The general practitioner reviews medication charts three-monthly. Staff who administer medications have completed annual competences.
Meals are prepared and cooked off-site by contractors. Individual and special dietary needs are accommodated. There are nutritious snacks available 24 hours per day in the dementia unit.

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 building has a current warrant of fitness.

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.

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

Infection prevention and control

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

The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Results of surveillance are acted upon, evaluated and reported to relevant personnel.

Summary of attainment

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

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	14	0	1	1	0	0
Criteria	1	38	0	1	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints policy and procedures are implemented and residents and their family/whānau have been provided with information on admission. Complaint and compliment forms are available at the service. Two caregivers and one registered nurse (RN) interviewed are aware of the complaints process and to whom they should direct complaints. An online complaints register has been maintained. There have been no complaints since 2014. Systems and processes are in place to ensure any complaints received are managed and resolved appropriately. Family members advised that they are aware of the complaints procedure and how to access forms.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment	FA	The two family members who visited on the day of audit stated they have been informed of their relative's changes in health status and any incidents/accidents. This is confirmed on the four incident forms reviewed. Family members also stated they and residents were welcomed on entry and were given time and explanation about services and procedures. Families receive newsletters that keep them informed on facility matters and upcoming events/activities. The service has policies and procedures available for access to interpreter services for residents (and their family/whānau).

conducive to effective communication.		
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Brian Wells is owned and operated by the Selwyn Foundation and is one of the services operating from the village site. The service provides care for up to 16 residents requiring secure dementia level care. On the day of the audit, there were 16 residents under the Aged Residential Care Agreement. The organisation is currently undergoing a restructure to increase clinical oversight of the increasing services. A village manager and group residential care manager (both registered nurses) oversee nine facilities within the village. A senior clinical manager has been recruited to commence in June 2017. A full-time registered nurse (RN) care lead has management responsibility for Brian Wells. The Selwyn foundation has an overarching business plan. The 2017 business plan includes goals for each service. The 2016 unit business plan has been reviewed and goals achieved included implementing a children's day, which has now become an annual event and also implementing the REAP programme (replenish, energy and protein) for residents with weight loss. The care lead has a post graduate Certificate in Health Science. She has attended the two-day aged care conference October 2016 and gerontology conference with specialist speakers.
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	The quality plan describes the Brian Wells quality improvement processes. The organisation wide risk management plan describes objectives, management controls and assigned responsibility. Progress with the quality and risk management programme has been monitored through the staff meeting with input from the organisations quality manager. All quality data is electronically logged and monitored by the care lead. Monthly meeting minutes have been maintained and evidence discussion around quality data including; accident/incidents, infection control, health and safety, complaints/compliments and quality improvement plans. Quality initiatives are identified and implemented such as reduction of falls and advance care planning. Staff interviewed confirm they read and sign minutes and any new/reviewed policies. A document control policy outlines the system implemented whereby all policies and procedures are reviewed regularly by relevant persons at head office. The internal audit schedule for 2016 and 2017 to date has been completed. Areas of non-compliance identified at audits have been actioned for improvement. The November 2015 annual survey identified a gap around communication channels. The focus for the 2016 survey was on communication channels for staff and residents, including the effectiveness of family newsletters. The result returned a 90% satisfaction survey result across the whole of the Selwyn Foundation. Results had been communicated to staff and residents/relatives. The service has implemented a health and safety management system. There are implemented risk management and health and safety policies and procedures in place including accident and hazard management. The board, executives and clinical governance have received updates around the new legislation. Selwyn has a health and

		safety group officer at head office. The service has a health and safety representative who has been in the role four years and has stages one, two and three of the recognized health and safety qualifications. There are specific health and safety goals for 2017 which include promoting a culture of reporting hazards. All of Selwyn health and safety representatives meet twice-yearly and this includes ongoing education. Health and safety including hazards are discussed at the monthly staff meeting. There is a current online hazard register that all staff can access.
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	Incident and accident data has been collected and analysed. Discussions with the service confirms that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. The DHB and MOH have been notified of one critical incident. There have been no outbreaks. A review of resident related incident reports for two falls in January 2017 and two falls to date for May 2017 were reviewed. All reports and corresponding resident files reviewed evidence that appropriate clinical care has been provided following an incident. The incident reporting policy includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. The service benchmarks incident data with other facilities in the Selwyn Foundation Group. Brian Wells exceeds the standard around management of incidents, particularly critical incidents.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. Copies of practising certificates are kept. Staff turnover is reported as low. Five staff files were reviewed (two RNs and three caregivers). All document a comprehensive orientation programme, appraisals and ongoing training. Staff are able to describe the orientation process and state that new staff are adequately orientated to the service. The service ensures that staff are trained by providing training according to set schedules and providing training in small groups to maximise staff understanding of the subject. The care lead has been trained (train the trainer sessions) to deliver the modules. All training is logged on a database and monitored by the organisations quality coordinator. All care staff receive comprehensive orientation. Selwyn Foundation has reviewed the orientation programme for caregivers in consultation with Careerforce. Once the caregiver has completed the orientation modules, they have achieved level two of the unit standards for residential care. The orientation is signed off by an on-site Careerforce assessor Appraisals are conducted three months post-employment and annually thereafter for all staff. A completed in-service calendar for 2016 exceeds eight hours annually and the 2017 in-service programme is being completed. The service has continued to improve its training programme in relation to orientation. The RNs are provided with

		ongoing training relevant to their roles. There are 12 caregivers who work in the dementia unit. Ten caregivers have completed the required dementia unit standards. Two caregivers who have been employed less than one year are in the process of completing the dementia unit standards.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	Brian Wells has a roster in place which provides sufficient staffing cover for the provision of care and service to residents. The care lead (a registered nurse) works full-time Monday to Friday and has clinical and management oversight of Brian Wells and Kerridge Rest Home. Two RNs (one full-time and one part-time) cover the morning shift seven days a week. There are three caregivers on morning duty (two full shifts and one short shift) and on afternoons three caregivers (two full shifts and one short shift). There are two caregivers on night shift. One caregiver on the morning and afternoon shift is allocated to activities oversight. The village RN is available on call after hours and sees any residents of concern. All staff have been trained in first aid. The Selwyn Foundation has its own bureau staff to fill vacant shifts through sickness or other leave.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate	There are medication management policies that align with required guidelines and legislation. The RN and senior caregivers responsible for the administering of medication complete medication competencies and attend annual medication education. The RN checks all medications (robotic sachets) on delivery against the medication chart. All medications sighted are within the expiry dates and all eye drops have been dated on opening. There were no self-medicating residents. The standing orders are not current. Ten medication charts sampled meet legislative prescribing requirements, however, not all medication has been signed as administered as prescribed. The GP has reviewed the medication charts at least three-monthly.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs	FA	An external contractor provides all meals from an on-site main kitchen. Food is transported in scan boxes to the Brian Wells unit kitchenette and served by the contracted kitchen assistants. The seasonal menus are reviewed by a dietitian, resident dislikes are known and alternative choices are offered for dislikes. The head chef (interviewed) provides residents' choice twice-weekly and chef's choice weekly. Residents with weight loss are commenced on the REAP (replenish, energy and protein) programme. Protein drinks are available in the facility fridge and there are plenty of nutritional snacks available in the dementia unit fridges and cupboards. Fridge, freezer, dishwasher and serving temperatures are checked and recorded daily. Kitchen staff have

are met where this service is a component of service delivery.		completed food handling training and chemical safety.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Low	When a resident's condition alters, the registered nurse or care lead initiates a review and if required, GP or specialist consultation. Not all care summaries have been updated to reflect changes in the resident's health. Dressing supplies are available. There are wound assessments, wound treatment plans and evaluation forms for four residents with wounds. However, dressings have not all been changed as per the documented frequency for dressing changes. Continence products are available. Bowel records are maintained. Specialist continence and wound care advice is available as needed and this could be described by the registered nurse.
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 service employs an activity coordinator two days a week and one caregiver on each duty is allocated activity oversight. Selwyn employs a qualified diversional therapist who oversees all the site activity programmes and meets regularly with the activity coordinator and care lead. The DT (interviewed) has been with Selwyn for two years. The activities programme is flexible and includes everyday meaningful activities such as gardening, walks and reminiscing. The activity coordinator and caregivers coordinate activities based on individual preferences and one-on-one time. New activities have been introduced since the previous audit including: "Baby Buddies" (mothers and babies who visit fortnightly though the Plunket group), poetry and performance sessions, dance expression held with university students, intergenerational activities and the introduction of PARO (an electronic seal designed to relieve anxiety). Volunteers are involved in playing music for the residents. Two art therapy students visit regularly who encourage art and drawing. Special events are celebrated. There are entertainers and church services held in the unit. The facility van is available all day for the residents on a weekly basis. Families are encouraged to join in on outings to the beaches, picnics, concerts and movie nights. Family input is sought to complete a resident lifestyle questionnaire. Individual activities identified as effective in de-escalating behaviours, are incorporated into the care plans. There are individual activity plans on file which are reviewed six-monthly. Resources are readily available for caregivers.
Standard 1.3.8: Evaluation Consumers' service	FA	Evaluation timeframes are specified in policies and procedures. Initial care summaries sighted have been evaluated by the RN within three weeks. There are six-monthly written care summary evaluations against the resident focused goals. Allied health professionals involved in the care of residents have input into care summary reviews.

delivery plans are evaluated in a comprehensive and timely manner.		Family/whānau are invited to provide input into the care review. Short term care plans are completed when there is a change of health status or the long term care plan is updated. However, not all care summaries have been updated to reflect changes in the resident's health (link 1.3.6.1)
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building has a current building warrant of fitness dated 16 January 2018.
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 and monitoring is an integral part of the infection control programme and is described in infection monitoring policy. The registered nurse is the designated infection control nurse. Infection control data is collected for all infections based on signs and symptoms of infection. All infections are individually logged on the electronic database. The data has been monitored and evaluated monthly and annually at facility and organisational level. An infection control report is provided at the monthly staff meeting. Infections are analysed for trends and corrective actions initiated where required.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Brian Wells continues to provide a restraint free environment. There is a restraint policy that included comprehensive restraint procedures and aligns with the standards. There were no residents using enablers. Staff are trained in the management of behaviours that challenge.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Moderate	The medication charts are pharmacy generated and meet legislative prescribing requirements. All ‘as required’ medications have indications for use. Seven of ten signing sheets correspond with the medication chart. There is a standing order in use that has not been reviewed annually.	1) Three medication signing sheets identify a medication had not been signed as administered as prescribed. 2) The standing order in use was last reviewed April 2015.	1) Ensure medications are administered as prescribed and signed. 2) Ensure the standing orders are reviewed annually. 60 days
Criterion 1.3.6.1	PA Low	There are a number of monitoring	1) Two of four wound evaluations have not been	1) Ensure

The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.		forms used to monitor the health status of residents, including: behaviour charts, pain assessments and monitoring tools, weight charts, bowel records, blood pressure and pulse charts, food and fluid intake charts and also continence monitoring. Four of five care summaries do not reflect the resident's current health status. Two wound evaluations have been completed as per the documented frequency.	completed as per the documented frequency on the wound treatment plan. 2) The care summaries do not reflect the resident's current health status in four of five files reviewed as follows: (i) One resident assessed at high risk of falls did not have appropriate falls prevention interventions; (ii) Interventions have not been updated to reflect one resident's current continence and behaviour status; (iii) One resident identified at risk of malnutrition (in interRAI), did not have any interventions documented to manage the risk; (iv) One resident who transferred from hospital level of care to the dementia care unit, did not have the care summary updated to reflect current supports/needs and interventions.	wound evaluations and dressing changes occur at the documented frequency. 2) Ensure all care summaries are updated to reflect the resident needs/supports. 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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.2.4.3 The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.	CI	When an incident occurs, the staff member finding the incident completes and incident form. Urgent matters after hours are dealt with by the on-call village registered nurse or by the RN or care lead during working hours. All incidents are electronically logged and quality improvement plans are raised when required. Incidents are benchmarked.	The service actively investigates critical incidents which includes immediate corrective action, preventative action/follow up as well as any learning opportunities. Resident related critical incidents are referred to the group residential care manager for investigation and reporting to the relevant authorities. The critical incident is entered into the critical incident register. The incident remains on the critical incident risk list until resolved and review occurred. The reviews for each incident are attended by key personnel involved in the incident and processes are looked at from both a facility level and from a company level. A staff debrief occurs. Brian Wells have had one critical incident (fall with fracture) in the last year. Corrective actions included placing a falling star sign on the doors and files of residents identified at high risk of falls. The service has remained under the benchmark for critical incidents.

End of the report.