# Selwyn Care Limited - Selwyn Sunningdale Village

## 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:** Selwyn Sunningdale Village

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

**Dates of audit:** Start date: 26 July 2017 End date: 27 July 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:** 25

# 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

Sunningdale Village is owned and operated by the Selwyn Foundation. The service cares for up to 33 residents requiring rest home or hospital level care. On the day of the audit there were 25 residents.

The service is managed by a village manager and an associate village manager and a care lead (all registered nurses) that divide their time between three Waikato sites. 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.

Improvements are required around care planning and medication 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. |

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. Individual care plans reference the cultural needs of residents. 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 can visit residents at times that meet their needs. 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. 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 are made as a result of trend analysis. Quality improvement plans are developed when service shortfalls 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. There is an annual education and training plan that exceeds eight hours annually. Residents and families report that staffing levels are adequate to meet the needs of the residents.

## Continuum of service delivery

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

The management team takes primary responsibility for managing entry to the service with assistance from the registered nurses. Comprehensive service information is available. Initial assessments are completed by a registered nurse, including interRAI assessments. The registered nurses complete care plans and evaluations within the required timeframes.

Residents interviewed confirmed they were involved in the care planning and review process. Each resident has access to an individual and group activities programme. The group programme is varied and interesting.

There are medication policies in place that comply with current legislation and guidelines. General practitioners review residents at least three-monthly or more frequently if needed.

Meals are prepared at another Selwyn Foundation site with the cook visiting Sunningdale often. The menu is developed under the direction of a dietitian. The menu is varied and appropriate. Individual and special dietary needs are catered for. Residents interviewed were complimentary about the food service.

## Safe and appropriate environment

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

The building has a current warrant of fitness and emergency evacuation plan. Ongoing and reactive maintenance issues are addressed. Chemicals are stored safely throughout the facility. There is sufficient space to allow the movement of residents around the facility using mobility aids. There is a main lounge and dining area, a library and other smaller seating areas. The internal areas can be ventilated and heated. The outdoor areas are safe and easily accessible. Documented policies and procedures for the cleaning and laundry services are implemented with monitoring systems in place to evaluate the effectiveness of these services. Staff have planned and implemented strategies for emergency management. Emergency systems are in place in the event of a fire or external disaster.

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

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. At the time of the audit there was one resident with a restraint and no residents using an enabler. Staff regularly receive training around restraint minimisation and the management of challenging behaviour.

## 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 as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner. There have been no outbreaks since the previous audit.

## Summary of attainment

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 48 | 0 | 0 | 2 | 0 | 0 |
| **Criteria** | 0 | 99 | 0 | 0 | 2 | 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 | The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in a visible location. Families and residents are provided with information on admission, which includes information about the Code. Staff receive training about resident rights at orientation and as part of the annual in-service programme. Interviews with seven care staff (three caregivers, three registered nurses (RN) and one diversional therapist) confirmed their understanding of the Code. Six residents (five rest home and one hospital level) and two relatives (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 five 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 resident files include information on resident’s 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 hours. 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 | Complaints policy and procedures have been implemented and residents and their family/whānau have been provided with information on admission. Complaint forms are available at the service. Residents interviewed confirmed they received information on the complaints process on admission and the care lead is very approachable should they have any concerns/complaints. Care staff interviewed are aware of the complaints process and to whom they should direct complaints. A complaints folder has been maintained. There have been twelve complaints received in 2016 and three made in 2017 year-to-date. All the complaints documentation included follow-up letters, investigations and resolutions that had been completed within the required timeframes. Corrective actions have been implemented and any changes required were made as a result of complaints. |
| 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. The care lead or RN 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. |
| 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 align with policy. Relatives interviewed confirmed that staff treat residents with respect. The service philosophy promotes quality of life and involves residents in decisions about their care. Resident preferences are identified during the admission and care planning process and include family involvement. Caregivers could describe how choice is incorporated into resident cares.  Caregivers have had training around recognition and prevention of abuse and neglect and actions they should take if this is identified. Caregivers interviewed could describe appropriate processes around this. |
| 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. The Selwyn Foundation works with their Tikanga partner through Te Pihopatanga O Te Taitokerau, which caters for all Iwi. During the audit, there were three residents that identified as Māori living at the facility. Māori cultural needs are addressed in the care plan. |
| 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 family/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/whānau are invited to attend. Discussions with two relatives confirmed that residents’ values and beliefs are considered. Six residents interviewed confirmed that staff consider 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/quality 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 (village manager, care lead and assistant village manager) 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 district health board (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 monthly staff/quality meetings. Residents and family interviewed advised that caregivers are caring and competent. Examples of good practice were evident including improvements to the activities programme. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | 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/accident into the system. Ten incident/accident reports reviewed met this requirement. Relatives interviewed confirmed they are notified following a change of health status of their family member. 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 Sunningdale village is owned and operated by the Selwyn Foundation. The service provides care for up to 33 residents requiring rest home or hospital level care. On the day of the audit there were 25 residents, 20 rest home residents (including one resident on a post-acute care contract and two residents on respite), there were five hospital level residents. All other residents were under the Aged Related Residential Care (ARRC) contract. There are four wings at Sunningdale village, El Alamein has nine beds of which eight are rest home only. The remaining 24 beds in the three other wings (Gallipoli, Casino and Crete) are dual-purpose.  The Selwyn foundation has an overarching five-year strategic plan 2013 to 2017, which includes the new model of care ‘The Selwyn Way’ which underpins how the Selwyn Foundation does things, in the context of its mission. The strategic plan also includes the organisational goals and these are reflected in the 2016 – 2017 Selwyn Sunningdale village business plan, which describes the vision, values and objectives of Selwyn Sunningdale village. Annual goals are linked to the business plan and reflect regular reviews via regular meetings. The village manager reports to the general manager (villages) regularly, on a variety of operational issues.  Selwyn Sunningdale village is managed by a village manager who is an RN and has been in the position for seven years. The village manager is supported by a care lead, who is an RN and has been in the role for nine months, and also an assistant village manager, who has been in the position for ten weeks. The care lead is supported by a senior RN and five other RNs. The village manager and care lead divide their time evenly between the three Selwyn Waikato facilities. The assistant village manager is located at Selwyn Sunningdale village and is also an experienced registered nurse.  The village manager has completed a minimum of eight hours of professional development relating to the management of an aged care service in the past twelve months. |
| 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 care lead and assistant village manager cover during the temporary absence of the village manager. |
| 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 group residential care manager. Discussions with the managers, the GP and staff reflected staff involvement in quality and risk management processes. Resident meetings are completed monthly. Meeting minutes are maintained. Annual resident and relative surveys are completed with results communicated to residents and staff. In 2016 the Selwyn Foundation completed a communication resident/relative survey to gain an understanding of the communication levels within the Selwyn Village.  The service has policies and 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. Clinical guidelines are in place to assist care staff. Updates to policies 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. This is utilised for service improvements. Key performance areas are benchmarked against other Selwyn facilities. Quality improvement plans (QIPs) are developed when service shortfalls are identified and these are monitored by group office. Results are communicated to staff at the monthly staff/quality meetings and reflect actions being implemented and signed off when completed.  Health and safety policies are implemented and monitored by the health and safety committee. The Selwyn Foundation health and safety committee meet monthly. Risk management, hazard control and emergency policies and procedures are in place. A health and safety representative was interviewed about the health and safety programme. 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 ten incident/accident forms from July 2017 identified that forms are fully completed and include follow-up by a RN. Neurological observations are completed for any suspected injury to the head. The care lead and RN are involved in the adverse event process. The village 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. |
| 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 (two RNs, two caregivers, one cleaner and one diversional therapist) included a recruitment process which included reference checking, signed employment contracts and job descriptions, completed orientation programmes and annual performance appraisals. Registered nursing staff and other health practitioner practising certificates are maintained on file.  The orientation programme provides new staff with relevant information for safe work practice. There is an 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. There is an attendance register for each training session and an individual staff member record of training. Two of the six RNs are interRAI trained. |
| 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. Rosters implement the staffing rationale. There is a full time village manager and full time care lead who divide their time evenly between the three Selwyn Waikato facilities. There is also a full time assistant village manager (senior RN) who is located at Sunningdale village full time. The village manager and care lead work also share the on-call duties. The care lead is supported by six RNs. There is one RN on the morning, afternoon and night shifts. Registered nurses are supported by sufficient numbers of caregivers.  Care staff levels were; three caregivers on the AM shift, three caregivers on the PM shift and two caregivers on the night shift. Staff were visible and were attending to call bells in a timely manner as confirmed by all resident and relatives interviewed. Staff interviewed stated that overall the staffing levels are satisfactory and that the managers provide good support. Selwyn Foundation has its own bureau of nursing staff to cover sick leave and annual leave. Residents and relatives interviewed reported 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. 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 RN including designation. |
| 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 | The service has comprehensive admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. The facility manager screens all potential residents prior to entry and records all admission enquires. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the manager. Five signed admission agreements were sighted. The admission agreement form in use aligns with contractual requirements. |
| 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 and ‘the yellow envelope’ is used. The RNs report that they include copies of all the required information in the envelope. |
| 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 | Ten medication charts were reviewed. There are policies available for safe medicine management that meet legislative requirements. The service uses an electronic medication management system for long-term residents of the house doctor and paper-based records for other residents. Not all medication charts sampled met legislative prescribing requirements. The medication charts reviewed identified that the GP had seen and reviewed the resident at least three-monthly.  All clinical staff who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Registered nurses interviewed could describe their role regarding medication administration. Administration records demonstrated that not all medications were administered as prescribed. The service currently uses a robotic roll system for medications. Staff report that all medications are checked on delivery against the medication chart but this is not documented.  Standing orders are in use and contraindications for each medication are documented. They are completed by the house doctor but had been administered to a short-term resident not under this doctor. There were no residents self-medicating on the day of audit.  The medication fridge temperature is recorded regularly and is within the acceptable ranges. |
| 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 | All meals at Sunningdale are prepared and cooked at a close-by sister site. They are transported to the service in hot boxes and then transferred into bain maries from which the kitchenhand serves the meals. There is a six-weekly seasonal menu, which was reviewed by a dietitian in April 2016. The temperature of the food is checked before leaving the kitchen. The kitchen staff were aware of all resident’s special dietary requirements on the day of audit. The cook visits the sites weekly and if residents are losing weight or not enjoying meals she discusses with them or their families what food they would prefer and this is provided. Individual resident likes and dislikes are accommodated. Pureed, gluten free and diabetic desserts are provided. Cultural and religious food preferences are met.  Staff were observed assisting residents with their meals and drinks. Supplements are provided to residents with identified weight loss issues. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed were very complimentary about the food and confirmed alternative food choices were offered for dislikes.  Fridge, freezer and chiller temperatures are taken and recorded daily. End cooked food temperatures are recorded daily. The dishwasher is checked regularly by the chemical supplier. Fridge temperatures are recorded for the fridges in each resident dining/servery area.  All food services staff have completed training in food safety and hygiene and chemical safety. |
| 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 prospective residents to the service is recorded. Should this occur, the manager stated it would be communicated to the potential resident/family/whānau and the appropriate referrer. Potential residents would only be declined if there were no beds available or if they could 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 | Four of five files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate (link 1.3.5.2). Four of five sampled contained appropriate assessment tools that were completed and in long-term files, assessments that were reviewed at least six monthly or when there was a change to a resident’s health condition. The interRAI assessment tool is implemented. Two of the six registered nurses are interRAI trained. InterRAI assessments have been completed for all long-term residents. Care plans sampled were not all developed on the basis of these assessments (link 1.3.5.2). |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Moderate | The care plans reviewed did not describe the support required to meet the resident’s goals and needs and identified allied health involvement. The service has a number of care plans in use (e.g., nursing care plan, lifestyle plan, short-term care plan, and wound care plan). The care plans reviewed were resident focused. The interRAI assessment process informs the development of the resident’s care plan. Residents and their family/whānau interviewed reported that they are involved in the care planning and review process. Short-term care plans are in use for changes in health status. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | A written record of each resident’s progress is documented. Resident changes in condition are followed-up by a registered nurse as evidenced in residents' progress notes. When a resident's condition alters, the registered nurse initiates a review and if required, GP or nurse specialist consultation.  In the files reviewed, short-term care plans were evidenced following a change in heath condition and linked to the nursing care plan documents (link 1.3.5.2). There was evidence in the files sampled of referral for specialist advice. Action plans documented by allied health practitioners had been implemented or documented in the nursing care plans.  Dressing supplies are available. Wound care documentation was reviewed for five residents with ten minor wounds (one resident had five wounds) and two residents with pressure injuries. Wound care assessments, plans and reviews including photographs were documented for all wounds and there was evidence of GP involvement in the management of wounds.  Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. Registered nurses could describe access to continence specialist input as required.  Monitoring forms are in use by the registered nurses. Forms sighted included monthly blood pressure and weights, pain monitoring, nutritional and food monitoring and behaviour monitoring and turning charts. |
| 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 diversional therapist works 30 hours per week and is supported by volunteers. Additionally, a music therapist runs a music group weekly. A wide range of activities addressing the abilities and needs of different residents (rest home and hospital) are offered and the attendance rate is high with residents of different abilities being supported to enthusiastically join in the activities.  A wide range of group activities are offered, many at the suggestion of residents. There is also significant engagement with the community including outings to clubs and concerts and a variety of groups and individuals from children to older people visit the service.  Activities included physical, mental, spiritual and social aspects of life to improve and maintain residents’ wellbeing.  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 are completed monthly. Reviews are conducted six-monthly (or earlier should the residents condition determine) as part of the care plan evaluation/review.  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. The diversional therapist has current first aid certificates. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The registered nurses evaluate all initial care plans within three weeks of admission. Files sampled demonstrated that the long-term nursing care plan was evaluated at least six-monthly or earlier if there is a change in health status (link 1.3.5.2). There was at least a three-monthly review by the GP. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files sampled. |
| 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 a referral to another service occurs. Registered nurses interviewed described the referral process should they require assistance. |
| 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 were secured in designated locked cupboards. Chemicals were labelled and safety datasheets were available throughout the facility and accessible to staff. Safe chemical handling training has been provided. Gloves, aprons, and goggles are available and staff were observed wearing personal protective clothing while carrying out their duties. |
| 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 which expires on 1 December 2017. There is a maintenance person employed to address the reactive and planned maintenance programme. All medical and electrical equipment was recently serviced and/or calibrated. Hot water temperatures are monitored and managed within 43-45 degrees Celsius. The facility has sufficient space for residents to mobilise using mobility aids. There are outside areas with seating, tables and shaded areas that are easily accessible. Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans. |
| 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 | Four resident rooms have full ensuite bathrooms and there are sufficient communal bathrooms and toilets to accommodate the needs of other residents. The ensuites and communal toilet facilities have privacy locks. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares. |
| 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 | All resident’s rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms and this has occurred. |
| 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 | There is a large communal lounge and dining area that is well used and several smaller areas including a library. Furniture is appropriate to the setting and arranged in a manner, which enables residents to mobilise freely. The main lounge is used for activities and a specific area for the hairdresser. The outdoor courtyards are also used for activities. |
| 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 | Dedicated cleaning staff are rostered on seven days per week. They have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme.  The laundry is all completed on-site and dedicated laundry staff are rostered on seven days per week. Laundry and cleaning staff interviewed advised that they had received training in chemical safety, infection control and waste management.  Cleaning products and laundry products are well labelled and kept in securely locked cupboards and chemical safety data guidelines are available.  The laundry and cleaning service has documented systems for monitoring the effectiveness and compliance with the service policies and procedures. Residents interviewed were satisfied with the standard of cleanliness in the facility and the laundry service. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | There is an emergency response and civil defence plan to guide staff in managing emergencies and disasters. There is a first aid trained staff member on every shift. There is a New Zealand Fire Service approved evacuation scheme with a covering letter dated 27 October 2000. The last trial evacuation was held on 21 March 2017 and was attended by 26 staff. The facility is powered by electricity and gas. There is an alternative energy supply in the event of the main supplies failing. The facility also has a gas BBQ, torches, and extra emergency ‘silver’ blankets. Emergency water is available on-site in boxed containers, enough for three litres per day for three days per resident. Emergency food supplies sufficient for three days, are kept in the kitchen. The facility has emergency lighting that lasts for four hours. The service has a defibrillator which is kept in the reception area.  There is an appropriate 'call system' available to summon assistance when required. Residents have access to a call bell in their rooms and in communal areas. The system is monitored from an electronic box in the nurses’ station. The internal audit programme monitors call bells every two months (last internal audit was done June 2017). There are procedures in place to ensure the safety and security of the residents at night. The security arrangements in place include locked doors and closed windows once dark and a security check is done at the midnight handover of caregivers. Sunningdale village has a critical incident plan (i.e., a major incident and health emergency plan) that covers how services are provided in a civil defence or other emergencies. The service holds adequate pandemic and outbreak supplies on-site and a civil defence emergency kit. |
| 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 Sunningdale 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 KPIs. A registered nurse is the designated infection control nurse with support from the clinical coordinator. The quality meeting team is 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 December 2016. |
| 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 Sunningdale 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 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 has occurred for staff. 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 onto 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. There have been no outbreaks since the previous audit. |
| 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 other de-escalation strategies have been ineffective. Restraint minimisation policies and procedures include definitions, processes and use of restraints and enablers. At the time of the audit there was one hospital resident with a restraint (bedrail) and no residents using an enabler. Staff training is in place around restraint minimisation 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. An RN is the restraint coordinator. 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. The one resident file where restraint was in use was reviewed. The completed assessment considered those listed in 2.2.2.1 (a) - (h). |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | 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. The use of restraint is linked to the residents’ care plans. Internal restraint audits measure staff compliance in following restraint procedures. Monitoring is documented on a specific restraint monitoring form, evidenced in the one resident file where restraint was being used. A restraint register is in place providing a record of restraint and enabler use. |
| 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 the RN and staff/quality meetings. A review of one resident file identified that evaluations were 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 RN 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/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 1.3.12.1  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 | Sunningdale Village uses an electronic medication documentation system for long-term residents under the house GP. Residents under different GPs or short-term residents have paper-based documentation. The three paper-based medication charts sampled had been documented by the residents own GP. One resident did not have dietary supplements documented as administered, and one resident (with a different GP) was administered medication from the house doctor’s standing orders. The registered nurses interviewed reported that the registered nurse on duty checks medications against the prescription when they are delivered. This sometimes occurs when agency staff are on duty and the checks are not documented to allow confirmation that this occurred. The house GP documents all ‘as required’ medications for long-term residents in the electronic system but not all had indications for use documented. | Three of the 10 medication records sampled were paper-based (as opposed to electronic). (i) One did not have Fortisip documented as administered, refused, withheld or not available. (ii) One had a medication documented on the prescription that was not in the robotic sachet and this had not been identified by staff. (iii) One had been administered paracetamol ‘from standing orders’ but there were no standing orders documented from this resident’s GP. (iv) The checks of packs on delivery are not documented. (v) Three of the ten medication charts sampled did not have indications for use documented for ‘as required’ medications. | (i) and (ii) Ensure all medications are administered as prescribed. (iii) Ensure standing orders are only used for residents under the care of the doctor that has documented the standing orders. (iv) Ensure that checks of medication packs on delivery are documented to allow monitoring of the process. (v) Ensure indications for use are documented for all ‘as required’ medications.  30 days |
| Criterion 1.3.5.2  Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Moderate | Registered nurses are responsible for developing resident care plans. All residents are intended to have an assessment and care plan developed within 24 hours of admission. This had occurred for four of the five resident files sampled. Care plans are written individually for each resident (as opposed to a templated document) but not all identified needs were addressed in the files sampled. | Four care plans did not have interventions documented for all identified needs. (i) One resident on mental health respite with significant mental health needs did not have these addressed in the initial care plan. (ii) One hospital resident did not have it identified that they are an amputee in the care plan, or mobility needs, continence needs, hearing needs or the need for regular creams applied to skin. (iii) One other hospital resident did not have the need to sit upright during and after meals, pressure injury risks or the ESBL positive status documented in the care plan. (iv) One rest home resident did not have behaviour management, communication issues or significant dementia addressed in the care plan. | Ensure all residents have a care plan that documents interventions for all identified needs.  60 days |

# Specific results for criterion where a continuous improvement has been recorded

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

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

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

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End of the report.