

Selwyn Care Limited - The Moxon Centre

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	Selwyn Care Limited
Premises audited:	The Moxon Centre
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 24 September 2018 End date: 25 September 2018
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:	15

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

The Moxon centre is owned and operated by the Selwyn Foundation. The service is designed to reflect Selwyn's household model of care. The service is purpose-built and has been operating since December 2017. The Moxon centre provides care for up to 24 residents requiring rest home or hospital level care. On the day of the audit there were 15 residents.

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, management and the general practitioner.

The service is managed by an experienced village manager/registered nurse who oversees three Waikato sites. She is supported by an experienced assistant village manager/registered nurse who is full-time at the Moxon Centre. The management team are supported by a team of registered nurses, house leads and care partners. Residents, relatives and the GP interviewed spoke positively about the new service and environment provided.

This audit has identified areas for improvement around the hazard register and care plan interventions.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Policies and procedures adhere to 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 a system in place for the management of complaints, which meets guidelines established by the Health and Disability Commissioner.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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A quality and risk management programme is being implemented. Data is collected on complaints, accident/incidents, infection control and restraint use. Quality and risk management data and performance is reported and discussed at the quality/staff meetings. Quality improvement plans are developed when service shortfalls are identified. There is a current business plan in place. Resident/relative (learning circles) meetings are held four-monthly. 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

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Residents are assessed prior to entry to the service. A baseline assessment is completed upon admission and an interRAI assessment within three weeks. Assessments, care plans and interventions are the responsibility of the registered nurses. InterRAI assessment tools and monitoring forms are used to assess the level of risk and ongoing support required for residents. There are multidisciplinary reviews six-monthly. The GP reviews the residents at least three-monthly. Referral documentation is maintained on resident files.

The activity programme includes participation in the village community activities and small group activities held in the households that are individualised to the resident preferences.

There are medication management policies that are comprehensive and direct staff in terms of their responsibilities in each stage of medication management. Registered nurses administer medications and complete annual competencies. The service uses an electronic medication system. The general practitioner reviews medication charts three-monthly or earlier if necessary.

The menu is designed and reviewed by a registered dietitian. Residents' individual needs are identified. There is a process in place to ensure changes to residents' dietary needs are communicated to the kitchen. The households have fully functional kitchens where baking and meals can be prepared as arranged.

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.
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The building has a certificate for public use. The building is currently under warranty for all maintenance concerns. Chemicals are stored safely throughout the facility. All resident rooms are spacious with ensuites. Each household of 12-beds has a kitchen and open plan dining and lounge area. There is sufficient space to allow the movement of residents around the facility using mobility aids. The internal areas are able to be ventilated and heated. The outdoor areas are safe and easily accessible. Cleaners are providing appropriate services. Staff have planned and implemented strategies for emergency management. Emergency systems are in place in the event of a fire or other emergency. There is a first aider on duty at all times. Laundry is completed off-site.

Emergency systems are in place in the event of a fire or external disaster. There are staff on duty 24/7 with a current first aid certificate.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. At the time of the audit there were no residents with restraints or using an enabler. Staff regularly receive training around restraint minimisation and the management of challenging behaviour.

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.
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control nurse (RN) is responsible for coordinating education and training for staff. The infection control nurse has completed annual training. There is a suite of infection control policies and guidelines to support practice. The infection control nurse uses the information obtained through surveillance to determine infection control activities and education needs within the facility.

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	43	0	1	1	0	0
Criteria	0	91	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 1.1.1: 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 eight care staff; four care partners (including one household lead), three registered nurses (RN) and one diversional therapist) confirmed their understanding of the Code. Eight residents (five rest home and three hospital) and one relative (rest home) 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	FA	The service has policies and procedures relating to informed consent and advanced directives. All five resident files (three rest home and two hospital level of care) reviewed included signed admission agreements that included consents given for treatment, transport and outings, photographs and release of medical information. Advance directives where known were on the files. Staff are aware of advanced directives. Resuscitation forms had been appropriately signed by the resident and their GP. Discussion with residents and families identified that the service actively involves them in decision making.

give informed consent.		
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	Residents interviewed confirmed they are aware of their right to access independent advocacy services. Discussions with the relative 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.
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	Residents and the relative interviewed confirmed that there are open visiting hours. The activities programme includes opportunities to attend events outside of the facility. Residents are supported and encouraged to remain involved in the community. Relatives and friends are encouraged to be involved with the service and care.
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	Complaints policy and procedures are in place 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 five complaints made since the Moxon Centre opened on 4 December 2017. All the complaints documentation included follow-up letters, investigations and resolutions that had been completed within the required timeframes.
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	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 the relative interviewed confirmed that information had been provided to them around the Code. Posters of the Code and advocacy information are displayed throughout the facility. A manager discusses the information pack with residents/relatives on admission. Families and residents are informed of the scope of services and any liability of payment for items not included in the scope.

<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>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. 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 (called care partners) could describe how choice is incorporated into resident cares. Care partners have had training around recognition and prevention of abuse and neglect and actions they should take if this is identified.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>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.</p>	FA	<p>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. At the time of the audit there were no residents that identified as Māori living at the facility. There is a local Kaumatua who visits on a regular basis for any cultural advice.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>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 one relative confirmed that residents' values and beliefs are considered and eight residents interviewed confirmed that staff consider their values and beliefs.</p>
<p>Standard 1.1.7:</p>	FA	<p>Staff job descriptions include responsibilities. The monthly quality/staff meetings include discussions around</p>

<p>Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>		<p>professional boundaries and concerns as they arise. Management provided guidelines and examples of mentoring for specific situations. Interviews with the managers (village manager and assistant village manager) and care staff confirmed their awareness of professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The Moxon Centre is operating using the 'The Selwyn Way' philosophy and the household model embedded in 'The Selwyn Way'. The Selwyn Way has been developed specifically for residential care using the integrated village model. It involves moving away from the conventional 'nursing facility' towards the aspiration of creating a true home (as opposed to an institution) for residents. The vision for the service is that residential aged care must be a place where older people are at home, where family enjoy visiting, where staff are caring and appreciated, where the care is good and life is worth living.</p> <p>Policies and procedures are aligned with current accepted best practice. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff. An annual in-service training programme for 2018 is being completed as per the training plan. Registered nurses are able to attend district health board (DHB) training and care partners 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 quality/staff meetings. Residents and the relative interviewed advised that care partners are caring and competent.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>There is an accident/incident reporting policy to guide staff in their responsibility around open disclosure. Staff are required to record family notification when entering an incident/accident into the (Lee Care) system. Fifteen incident/accident forms reviewed met this requirement. The relative 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.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation</p>	<p>FA</p>	<p>The Moxon Centre is owned and operated by the Selwyn Foundation. The Moxon Centre is a new care centre situated within a retirement village complex. The centre is a three-level facility. The ground floor includes the service areas, and the second floor includes serviced apartments (LTO's only). There are 24 (rest home and hospital level) rooms on the 1st floor (all dual-purpose), across two households. At the time of the audit there</p>

<p>ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>		<p>were 15 residents in total, 11 rest home residents and four hospital residents. All residents are under the aged related residential care (ARRC) agreement.</p> <p>The Moxon Centre is operating using the 'The Selwyn Way' philosophy and the household model embedded in 'The Selwyn Way'. The Selwyn Way has been developed specifically for residential care using the integrated village model. It involves moving away from the conventional 'nursing facility' towards the aspiration of creating a true home (as opposed to an institution) for residents. The vision for the service is that residential aged care must be a place where older people are at home, where family enjoy visiting, where staff are caring and appreciated, where the care is good and life is worth living.</p> <p>The Selwyn foundation has an overarching five-year strategic plan 2018 to 2022, which includes the new model of care 'The Selwyn Way' which underpins how the Selwyn Foundation operates, in the context of its mission. The strategic plan also includes the organisational goals and these are reflected in the 2018/2019 Moxon Centre business plan, which describes the vision, values and objectives of the Moxon Centre. Annual goals are linked to the business plan and reflect regular reviews. The village manager/Waikato reports to the operations manager residential care monthly on a variety of operational issues.</p> <p>The service has a village manager who is an experienced aged care RN and has been in the village manager role for the Selwyn Foundation Waikato region prior to the opening of the Moxon Centre. The village manager works at the Moxon Centre for two and a half days and the rest of the time at the two other facilities under the Waikato region (Sunningdale and Wilson Carlile). The village manager is supported by an assistant village manager, who is an RN and has been in the role for one month and at the Selwyn Foundation for 18 months. The assistant village manager (RN) is there full-time. The village manager and assistant manager are supported by the operations manager for residential care.</p> <p>The village manager and assistant 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.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe</p>	<p>FA</p>	<p>The assistant village manager covers during the temporary absence of the village manager with the support of the RNs and care staff.</p>

services to consumers.		
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	PA Low	<p>A quality and risk management system is being implemented into practice. Data is collected on complaints, accident/incidents, infection control and restraint use. Quality and risk management performance is reported and discussed at the quality/staff meetings. Resident (learning circles) meetings are completed four-monthly. Meeting minutes are maintained. 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.</p> <p>The service's policies are reviewed at a national level by the clinical governance group with input from facility staff every two years. The quality monitoring programme is designed to monitor contractual and standards compliance, the quality of service delivery in the facility and across the organisation. There are clear guidelines and templates for reporting. The facility has processes in place to collect, analyse and evaluate quality data. Results are communicated to staff at the monthly quality/staff meetings. Key performance areas are benchmarked against other Selwyn facilities. Quality improvement plans (QIPs) are developed when service shortfalls are identified.</p> <p>A resident and relative survey is to be completed annually with the first residents/relatives survey, due to be completed at the end of 2018. A health and safety representative (care partner) was interviewed about the health and safety programme. Risk management, hazard control and emergency policies and procedures are documented, however the hazard register was overdue for review. Falls prevention strategies are in place, which include the identification of interventions on a case-by-case basis to minimise future falls.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>There is an incident/accident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise and debriefing. Individual incident/accident reports are completed for each incident/accident with immediate action noted and any follow-up action required. A review of fifteen incident/accident forms from across June - August 2018 identified that forms were fully completed and include follow-up by a RN. Neurological observations were completed for twelve unwitnessed falls or suspected injury to the head. The village manager and assistant village manager were able to identify situations that would be reported to statutory authorities including (but not limited to) infectious diseases, serious accidents and unexpected death. There have been no section 31 notifications required since the Moxon Centre opened in December 2017.</p>

<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Human resources policies include recruitment, selection, orientation and staff training and development. Six staff files reviewed; one assistant village manager, two RNs and three care partners (including one household lead) included a recruitment process which included reference checking, signed employment contracts and job descriptions, completed orientation programmes and annual performance appraisals. The orientation programme provides new staff with relevant information for safe work practice.</p> <p>Registered nursing staff and other health practitioner practising certificates are maintained on file. There is an annual education and training plan for 2018 that exceeds eight hours annually. The training plan is being 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. There is an attendance register for each training session and an individual staff member record of training. Three of the six RNs are interRAI trained.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>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 (who is located for two and a half days at the Moxon centre) and assistant village manager (RN), who works full time at the Moxon Centre full time. Selwyn Foundation has its own bureau of nursing staff to cover sick leave and annual leave. Residents and the relative interviewed reported there are sufficient staff numbers. The village manager and assistant village manager share the on-call duties. They are supported by six RNs. There is 24-hour RN cover with one RN on duty during the morning and afternoon shifts and one RN on the night shift. Registered nurses are supported by sufficient numbers of care partners.</p> <p>The Moxon Centre is split into two 12-bed households with 24 beds in total. The two households are adjacent to each other on level one. In household one there are 11 of 12 residents (eight rest home and three hospital). There are two care partners (including one household lead) on the morning shift, two care partners on the afternoon shift and one care partner on the night shift. In household two there are four of 12 residents (three rest home and one hospital). There are two care partners on the morning shift and one on the afternoon shift. The care partner from household one covers the night shift. During the audit the care staff were visible in attending to call bells in a timely manner. Staff interviewed stated that overall the staffing levels are satisfactory and that the managers provide good support.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable,</p>	<p>FA</p>	<p>The resident files were appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. 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 care partner or RN, including designation.</p>

accurately recorded, current, confidential, and accessible when required.		
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>All residents are assessed prior to entry for rest home or hospital level of care. The service has specific information available for residents/families/whānau at entry and includes associated information such as the Code of Rights, advocacy and the complaints procedure.</p> <p>An admission booklet is available to all residents/family/whānau on enquiry or admission. The information includes examples of how services can be accessed that are not included in the agreement. Five signed admission agreements were sighted. The admission agreement reviewed aligns with a) – k) of the ARC contract. Exclusions from the service are included in the admission agreement.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>The service has transfer/discharge/exit policy and procedures in place. All transfer and discharge summaries are kept on the resident file. Relatives are informed and involved in discussions regarding transfers to hospital.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>There are medication management policies that align with required guidelines and legislation. The RNs are responsible for the administering of medication and complete medication competencies, syringe driver training and attend medication education. Senior care staff complete competencies to check restricted medications and insulin. All medications are stored safely. There is a locked medication room where pharmaceuticals are stored. Each household had a locked medication cupboard with a medication trolley and medication fridge. Medication fridge temperatures were maintained within the acceptable range. The RN checks all medications (robotic rolls) on delivery against the electronic medication chart. All medication sighted was within the expiry dates and all eye drops were dated on opening. Bulk supply medications are available for hospital level residents. There were no self-medicating residents on the day of audit.</p> <p>Ten medication charts reviewed on the electronic medication system met legislative prescribing requirements. All medication charts had photo identification and allergy status identified. The GP had reviewed the medication charts at least three-monthly.</p>

<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>A chef manager (interviewed) oversees the food services for Selwyn facilities in the Waikato region including Selwyn Moxon. The main kitchen is on the ground floor adjacent to the dining area for the independent living apartments. There is a chef and cook/kitchenhand on duty each day from 8.30 to 5pm. Breakfast is made and served in the households by the house lead/care partners. Food services staff have completed food handling training and chemical safety. Breakfast time was observed to be relaxing with residents attending the dining room at various times. Breakfast was individualised to the resident preference including a cooked breakfast as desired. The four-weekly menu has been reviewed by a dietitian November 2017 and provides a choice of two options. There is a weekly resident choice. The meals (in covered dishes) are transported in hot/cold scan boxes using the service lift to the households. Dislikes are known and dietary requirements are provided including mince/moist and pureed meals. The chef is notified of any dietary changes or requirements. The house lead in discussion with residents may choose to make their own morning and afternoon teas or lunch/dinner meals. This is arranged beforehand with the Chef Manager/chef to ensure the nutritional value of the meals have not been compromised. Each household has a pantry and fridge-freezer that was well stocked. The house lead completes a daily order of food items required. The service purchases pureed foods to ensure a high nutritional value is provided for pureed meals, soups and other foods.</p> <p>The food control plan has been verified with MPI (ministry of primary industries) and expires 1 November 2018. Daily chiller/fridge (including the households), freezer, dishwasher and delivery of chilled goods temperatures are taken and recorded. End cooked temperatures are taken and recorded on main meals and all critical foods on the menu. The chemical provider conducts service checks monthly on chemicals and dishwasher. A cleaning schedule is maintained.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>The reason for declining service entry for residents to the service is recorded. Should this occur, the service stated it would be communicated to the resident/family/whānau and the appropriate referrer. Potential residents would only be declined if there were no beds available or they did not meet the service requirements</p>

<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>The resident's needs, support requirements and preferences were collected and recorded within required timeframes. Information is also gathered from medical notes, discharge summaries, allied health involvement and from discussion with the resident/relatives on admission. The RNs complete applicable assessment tools on admission such as falls risk, pressure risk, dietary needs, continence, pain, mobility, cognitive and depression. The outcomes of these assessments were reflected in the initial care plan. The first interRAI assessment had been completed within 21 days and the outcomes reflected in the long-term care plan. InterRAI assessments are completed at least six-monthly or when there is a change to health status.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>Five long-term care plans reviewed were resident focused and involved resident/relative input into care. An initial plan of care was developed on admission for all resident files reviewed. Long-term plans were developed within three weeks of admission and evaluated six-monthly. The electronic progress notes document communication with the family regarding the development and review of care plans. The long-term care plans and care summaries are updated as changes occur to health, however not all care plans reflected current supports required. The care plans demonstrate allied health involvement in resident care.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>When a resident's condition alters, the registered nurse initiates a review and if required, GP or NP consultation. The residents and relatives interviewed confirmed their expectations were being met. There is evidence of communication with the relatives in the electronic progress notes including infections, medication changes, accidents/incidents, GP visits and any other changes to care.</p> <p>Dressing supplies are available. There were wound assessments, wound treatment plans and wound evaluation forms in place for two residents with wounds. There were no pressure injuries on the day of audit. The service has access to a wound nurse specialist as required.</p> <p>Continence products are available. Bowel records are maintained. Specialist continence advice is available as needed and this could be described by the registered nurse. There are a number of monitoring forms used to monitor the health status of resident's including blood sugar levels (on Leecare), behaviour charts, pain assessments and monitoring tools, weight charts, neurological observations, blood pressure and pulse charts, food and fluid intake charts and continence monitoring. Care partners maintain daily hygiene and care provision records.</p>
<p>Standard 1.3.7: Planned Activities</p>	<p>FA</p>	<p>The service employs a diversional therapist (DT) who covers three local Selwyn facilities. The DT oversees the house leads and care partners who initiate activities in each household each day to reflect the resident's</p>

<p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>preferences. There is a weekly village programme of activities which is held within the community on the ground floor. The ground floor is designed to represent a street with the services set off from the street including a large activity lounge, library and computer room (maintained by the residents), craft room, café, GP room and hairdressers. A shop is under development. The residents can choose to attend the village activities held in the community lounge including (but not limited to) book club, cards, craft group, bingo, happy hour, Mah Jong, Tai Chi and film afternoons. Staff assist residents (rest home and hospital) to attend community activities on the ground floor. Small group activities of choice occur within the household lounges such as board games, exercises, walks crafts, high teas, gardening and baking. Small group activities were observed in the household. Residents interviewed were happy with the activities offered and the ladies enjoyed being able to bake in the household kitchen. Residents also choose to complete hobbies and activities within their spacious rooms and one-on-one time is spent with residents who choose not to participate in the home activities. Village volunteers visit to read the newspaper or novels to the residents.</p> <p>There are entertainers, choirs and cultural dancers who entertain in the centre activity lounge and the households. Residents are encouraged to maintain links with the outside community such as attending stroke club and Cambridge Hall events. Church services are held in the village chapel and there is a Selwyn Chaplain who visits residents weekly. There is a volunteer van driver currently completing van driver competency so that regular outings can commence in the shared van (with the village). Pet therapy is scheduled to commence visits to the centre.</p> <p>The leisure and recreational assessments are completed on lee-care and activity plans are reviewed six-monthly as part of the multidisciplinary review. "Learning circles" (discussions) are held with residents with the opportunity for feedback on all areas of the service. Residents interviewed commented positively on the activities offered.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Evaluation timeframes are specified in policies and procedures. Initial care plans sighted were evaluated by the RN within three weeks. There are six-monthly written multidisciplinary care plan evaluations against the resident focused goals. A resident review record is kept on the resident file and includes input from the RN, GP, physiotherapist (as applicable), activities team, other allied health professionals as applicable and the resident/relative. The long-term care plans are updated following an evaluation to reflect changes in care (link 1.3.5.2). The GP reviews the resident at least six-monthly.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p>	<p>FA</p>	<p>The service facilitates access to other services (medical and non-medical) and where access occurs, referral documentation is maintained. Residents' and/ or their family/whānau are involved as appropriate when referral to another service occurs. Registered nurses interviewed described the referral process should they require assistance.</p>

<p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>		
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>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 a designated locked room. Chemicals were labelled, and safety data sheets were available. There is a pre-mixed dispensing system for the re-filling of chemical bottles. All staff have completed safe chemical handling training. Personal protective equipment/clothing was sighted in the sluice room. Staff were observed wearing protective equipment when carrying out their duties and demonstrated knowledge of handling chemicals.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The service displays a certificate of public use certificate that expires 29 November 2018. The maintenance manager (interviewed) covers the three Selwyn sites in the Waikato region. He has been spending 25 hours a week at Moxon centre and is available on call. Any maintenance requests are currently referred to the main contractor as the building is still under warranty. Thereafter, a maintenance work notification book will be used for staff to communicate with maintenance staff about issues and areas that requires attention. There are essential contractors available 24 hours. Hot water temperatures in the resident ensuites are monitored and recorded monthly. Selwyn Foundation has maintenance plans in place that include the checking of resident equipment. All equipment was newly purchased on opening and have been tested and tagged September 2018. Clinical equipment has been calibrated September 2018.</p> <p>The communal areas are spacious and there is sufficient space for residents to manoeuvre safely with the use of mobility aids</p> <p>There are outside areas with seating, tables and shaded areas that are easily accessible. The two household residents on the first floor have access to an outdoor balcony with seating, shade and raised gardens. Care staff interviewed stated they had sufficient clinical equipment to safely deliver care as described in the care</p>

		plans including chair scales, electric beds and hoists.
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	All resident rooms have shower/toilet and hand basin ensembles. There are communal toilets close to communal activity areas. Communal toilet facilities have privacy locks.
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	There are two households each with 12 resident rooms. The rooms are spacious, are of an adequate size to allow care to be provided and for the safe use and manoeuvring of mobility aids including hoists and electric wheelchairs. The resident rooms have individualised décor and furnishings. Residents are encouraged to personalize their rooms as viewed on the day of audit. There are large wardrobes in the resident rooms and valuables safes provided.
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and</p>	FA	The ground floor has community areas for independent living residents and residents living in the households. This includes a large activity lounge, library and computer room (maintained by the residents), craft room, café and dining area, GP room and hairdressers. A shop is under development. Each household has a functional kitchen with a central island facing the dining area promoting socialisation and conversation while preparing/serving meals. Household one has an open plan kitchen/dining and lounge and household two has an open kitchen and dining area with a separate lounge area. Each household has a "den" (family/activity room) where visitors/family can meet or quieter activities can take place. The "dens" have a fold away bed to accommodate family as required. All areas are easily accessible for rest home and hospital residents.

<p>accessible areas to meet their relaxation, activity, and dining needs.</p>		
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>All personal laundry and linen is completed off-site at a central laundry. There is a small domestic laundry in the household floor that can be used for delicates. Dirty laundry bags are sent downstairs via a chute in the sluice room to a designated area and trolley. There is a daily pickup of dirty laundry and drop off for clean linen trolleys and personal clothing via the service delivery door. Residents and relatives expressed satisfaction with cleaning and laundry services.</p> <p>The service employs a nightshift cleaner from 11pm to 7am who completes cleaning duties on the ground floor and household floor in the non-resident sleeping areas. One care partner on the morning and afternoon shift are designated cleaning duties including the ensuite. The cleaning trolley have locked chemical boxes built into the trolley. All trolleys are kept in designated areas when not in use.</p> <p>Cleaning and laundry processes are monitored for effectiveness through internal audits and feedback from residents. Staff have completed chemical safety training.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>There is an emergency response and civil defence plan in place 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 13 October 2017. A fire evacuation drill is completed six-monthly with the last drill occurring on 26 July 2018. Sufficient emergency water is available on-site in a water tank (2,400 litres) and bottled water stored to ensure for three litres per day for three days per resident. Emergency food supplies sufficient for three days are available. The service has alternative cooking facilities (BBQ). The service has a backup system for emergency lighting and battery backup for up to four hours. Extra blankets, torches and batteries are available.</p> <p>Call bells are evident in residents' rooms, lounge areas and toilets/bathrooms. Residents were sighted to have call bells within reach during the audit and this was confirmed during residents and relative interviews. The service has a visitor's book at reception for all visitors, including contractors, to sign in and out. There are procedures in place to ensure the safety and security of the residents at night. A security check is done at the 11.00pm handover of care partners. The Moxon Centre 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 that is checked six-monthly last occurring in July 2018.</p>

<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>Residents are provided with adequate natural light, safe ventilation and an environment that is maintained at a safe and comfortable temperature. The facility has underfloor heating.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>Selwyn Moxon has an infection control programme appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system and the Selwyn KPI's. A senior registered nurse is the designated infection control nurse with a job description and has been an infection control nurse since June 2017 with another Selwyn site. The infection control programme is reviewed annually in March by the clinical quality manager at head office in discussion with all Selwyn infection control nurses.</p> <p>Residents are offered the annual influenza vaccines. Visitors are asked not to visit if unwell. Hand sanitizers are appropriately placed within the facility.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse has completed an infection control training and education day twice yearly with other Selwyn IC nurses. The IC nurse has good external support from expertise with Selwyn, IC nurse specialist at the DHB, GPs, laboratory services and external infection control specialists</p>

<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>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.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The infection control nurse coordinates and implements Infection prevention and control as part of staff orientation and induction. All staff employed completed inductions as part of the orientation to the new facility. Infection control workbooks are completed for care partners/administration/maintenance and for qualified staff. Infection control education is scheduled to occur annually. Internal audits demonstrate staff knowledge and competency in infection control practices.</p> <p>Resident education is expected to occur as part of daily cares.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been</p>	<p>FA</p>	<p>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 and has the responsibility for collecting infection control data based on signs and symptoms of infection. Infections are individually logged on the electronic database and benchmarked against other Selwyn facilities. The data has been monitored and evaluated monthly. Data is reported to the management and staff meetings. Meeting minutes are available in the staff office. Infections are analysed for trends and corrective actions initiated where required.</p> <p>There have been no outbreaks since the opening of the building.</p>

specified in the infection control programme.		
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 were no residents with restraints or using an enabler. Staff training is in place around restraint minimisation and management of challenging behaviours, last occurring in March 2018.

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)
<p>Criterion 1.2.3.9</p> <p>Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:</p> <p>(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;</p> <p>(b) A process that addresses/treats the risks associated with service provision is developed and implemented.</p>	PA Low	Emergency policies and procedures are being documented. There is a hazard register that is overdue for review.	The hazard register is dated January 2017 and has not been reviewed or updated since opening.	<p>Ensure the hazard register is reviewed and updated.</p> <p>90 days</p>

<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA Moderate</p>	<p>Care plans identify the resident supports and required interventions to meet the resident goals. Interventions for daily activities of living and recreation are focused around promoting and maintain independence within a household model of care. Three of five care plan summaries did not reflect the residents current clinical/medical status.</p>	<p>Not all interventions had been documented to meet the resident's current health status as follows; (i) signs, symptoms and management of hypo/hyperglycaemia had not been documented for one insulin dependent rest home resident. The resident's pain had not been identified on the care summary; (ii) the care summary does not identify a hospital resident at risk of choking. The same resident (at high risk of falls) had hip pain requiring GP intervention which has not been identified on the care summary, and (iii) there is no weight management record for two hospital residents with weight loss.</p>	<p>Ensure all interventions are documented to support the resident's current needs and supports.</p> <p>90 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.