

Selwyn Care Limited - Kerridge House

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Selwyn Care Limited
Premises audited:	Kerridge House
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 12 December 2018 End date: 13 December 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:	54

Executive summary of the audit

Introduction

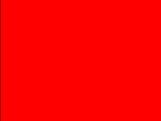
This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

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

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

Key to the indicators

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

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

General overview of the audit

Selwyn Kerridge House is owned and operated by the Selwyn Foundation and is one of four services operating from the village site. The service provides care for up to 60 residents requiring rest home or hospital level of care (dual-purpose beds). There are currently 54 residents requiring rest home level of care in the service.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, family, management, a general practitioner and staff.

The aged care facilities on the site, including Selwyn Kerridge House are overseen by a village manager, who has extensive experience in managing care facilities. Selwyn Kerridge House is managed by a care manager, who is a registered nurse (RN) and has been in the role for two months.

Three of the four shortfalls identified at the previous audit have been addressed. These are related to internal audits, medication documentation and wound documentation. Further improvements continue to be required around complaints management.

This audit also identified improvements required to the following: business planning; training; six monthly completion of interRAI assessments; six monthly review of the activities plans; interventions, medication competencies for staff administering medications and dietary profiles provided to kitchen staff.

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.

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

Residents are provided with information they need on entry to the service and this is regularly updated. Interviews with residents and family confirmed they are provided with adequate information and that communication is open.

Communication records are maintained in each resident record. Residents are informed of the complaints process and there are policies and procedures in place to investigate complaints. A register of complaints is kept.

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 medium or high risk and/or unattained and of low risk.

There is a village manager and care manager who provide operational management and clinical management for the service.

There is an implemented quality and risk management programme. Adverse, unplanned, and untoward events are documented by staff and reviewed by the care manager. All aspects of the quality programme are discussed at relevant meetings. The health and safety programme meets current legislative requirements.

Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff, with one recently developed for bureau staff. A staff education and training programme is embedded into practice. Registered nursing cover is provided on a morning and afternoon shift, seven days a week. The residents' files are appropriate to the service type.

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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Assessments, care plans, interventions and evaluations are completed by the registered nurses. Allied health professional involvement in the resident's care is documented as per individual need.

There is an activities coordinator currently delivering the activities programme with assistance from an experienced caregiver. The service is recruiting into the role of a second activities coordinator. The activity programme is based on resident preference and participation and activities meet the individual recreational needs and includes community involvement, entertainment and visits into the community.

There are medicine management policies in place that meets legislative requirements. Registered nurses and identified care supervisors administer medication. The general practitioner reviews the medication charts three-monthly.

The food service is contracted to an external company. Residents have choice around what they would like to eat. Staff have attended food safety and hygiene training.

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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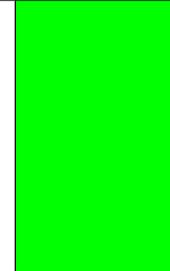
Restraint minimisation and safe practice

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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Staff regularly receive training around restraint minimisation and the management of challenging behaviour. There are no restraint and enablers used in the service currently.

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.

A surveillance programme is documented and undertaken, and this is appropriate to the size and complexity of the service. 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	10	0	5	3	0	0
Criteria	0	36	0	5	3	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>PA Low</p>	<p>There is a 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.</p> <p>Six residents confirmed that they received information on the complaints process on admission and the care manager is very approachable should they have any concerns/complaints.</p> <p>Care staff interviewed, are aware of the complaints process and to whom they should direct complaints. A complaints register is maintained, however seven of the eight complaints made in 2018 did not have any documented follow up, investigation or outcome resolutions. The corrective action identified at the previous audit remains.</p> <p>The Ministry of Health requested follow-up against aspects of a complaint from the Health and Disability Commission that included human resource management; service provider availability (training); falls risk assessment and pain assessments; planning and timely referral to other services when needed. This audit has identified issues with staff training and completion of assessments in a timely manner and care planning. There were no concerns related to orientation and induction; or to timely referrals to other appropriate services when needed).</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 into the system. Fifteen of fifteen incident/accident reports reviewed meet this requirement.</p> <p>Three 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 are available.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>PA Low</p>	<p>Selwyn Kerridge House is owned and operated by the Selwyn Foundation. There has been an opening of a new hospital level care facility on the same site as Selwyn Kerridge and all residents identified as requiring hospital level of care at Selwyn Kerridge have been transferred to that facility. The Selwyn Caswell facility also on the same site has been shut down and residents requiring rest home level of care have been transferred to Selwyn Kerridge.</p> <p>The service provides care for up to 60 residents requiring rest home or hospital level care. On the day of the audit there were 54 residents all requiring rest home level of care. All residents are under the Age Related Residential Care (ARRC).</p> <p>The aged care facilities on the site, including Selwyn Kerridge House are overseen by the village manager, who has been in the position for over four years. Selwyn Kerridge is managed by a care manager (a registered nurse) who has been in the role for just over two months. Both managers have extensive experience in aged care and in managing aged care facilities. The care manager has a Masters of Nursing, which has been approved by the Qualifications Authority of New Zealand. The care manager is supported by a team of registered nurses.</p> <p>The Selwyn Foundation has an overarching five-year strategic plan 2018 to 2022. The strategic plan includes the mission statement, vision and values of the organisation. There is a business plan to June 2018, however this has not been reviewed and a new plan for 2018 to 2019 is not yet in place.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous</p>	<p>FA</p>	<p>There is an established quality and risk management system in place. Quality and risk performance is reported across facility meetings. Discussions with the managers, the general practitioner and staff, reflect staff involvement in quality and risk management processes.</p> <p>Resident meetings are completed monthly. Meeting minutes are maintained. Resident and relative surveys are completed with results communicated to residents and staff. A corrective action plan from the last resident survey has shown improvements in service delivery and in the environment. The family satisfaction survey</p>

<p>quality improvement principles.</p>		<p>has been completed in the past month and is currently being collated.</p> <p>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 include procedures around the implementation of interRAI. The internal audit schedule for 2018 has been implemented. Internal audits reviewed for 2018 confirmed that these had corrective actions in place and showed evidence of resolution of issues. The improvement required at the previous audit has been addressed.</p> <p>The quality monitoring programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation. There are clear guidelines and templates for reporting. Key performance areas are benchmarked against other Selwyn facilities. Corrective action plans have already been put in place by the new care manager to address issues they have identified since being in the role.</p> <p>The Selwyn Foundation Health and Safety Committee meet monthly and health and safety policies are implemented and monitored by the committee. Risk management, hazard control and emergency policies and procedures are in place with staff able to describe these. A health and safety representative (care supervisor) was interviewed about the health and safety programme and they clearly understood their role in escalating issues and in being a part of discussions related to health and safety. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made.</p> <p>Falls prevention strategies are in place, including use of sensor mats; increased monitoring; identification and meeting of individual needs.</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>	<p>FA</p>	<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 October 2018 identified that forms are fully completed and include follow-up by the care manager. Neurological observations are completed for any suspected injury to the head or for an unwitnessed fall.</p> <p>The managers interviewed understand their role in reporting any incident to an external authority. The Ministry of Health and the district health board has been informed of the appointment of the care manager.</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>PA Moderate</p>	<p>Human resources policies include recruitment, selection, orientation and staff training and development. Six staff files reviewed (one village manager, care manager, one RN, one caregiver, one care supervisor and activities coordinator) documented a recruitment process which includes reference checking; signed employment contracts and job descriptions; completed orientation programmes and annual performance appraisals.</p> <p>Registered nursing staff and other health practitioner practising certificates are maintained on file. All reviewed, evidenced current annual practicing certificates.</p> <p>The orientation programme provides new staff with relevant information for safe work practice. There is an annual education and training plan documented that exceeds eight hours annually if implemented. The training plan has not been implemented between April 2017 and May 2018 and an improvement is required.</p> <p>Three of six registered nurses and the care manager have completed interRAI training and have maintained their competency.</p> <p>Bureau staff are orientated with competencies completed.</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. The care manager (RN) works full-time Monday to Friday and is available on call 24/7. They are supported by three registered nurses with other bureau nurses rostered to cover any leave or vacancy. There is a registered nurse on duty on each morning and afternoon shift seven days a week.</p> <p>There are also five care supervisors (senior caregivers) who are responsible for supporting caregivers and for making sure that cares have been provided. A care supervisor is rostered onto each shift.</p> <p>The registered nurses are supported by sufficient numbers of caregivers. Care staff levels as per rosters reviewed, are seven caregivers including a care supervisor in the AM shift; six caregivers in the PM shift including a care supervisor and two caregivers at night. Staff are allocated to either one of the two wings, however staff stated that they work as a team and help across both wings if needed.</p> <p>Staff are visible and attend 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 care manager provides good support. Residents and relatives interviewed reported there are sufficient staff numbers. Selwyn Foundation has its own bureau of nursing staff to cover sick leave and annual leave.</p> <p>The care manager is actively recruiting to fill vacancies for registered nurses, caregivers and for an activities coordinator.</p> <p>The village manager is available on call if required. There has been a low staff turnover until very recently</p>

		when some staff have been transferred to work in the new hospital building on site.
<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>	<p>PA Moderate</p>	<p>The medication management policies and procedures are documented with staff able to describe practice as per policy. The service uses an electronic system for prescribing and documentation of administration of medication.</p> <p>Resident medicines are stored securely in the medication room/cupboards with controlled drugs being in a locked safe in a locked room. Two medication rounds were observed and both staff administered medicines as per policy. There is evidence of three-monthly reviews by the general practitioner with reviews being more frequently provided if required.</p> <p>The care manager, registered nurses and care supervisors administer medicines. There is a competency for use of the electronic system with all staff who administer medication having completed this. Staff have not completed an annual medication competency and not all staff have completed training around medication.</p> <p>Ten individual resident medication charts were sighted. Resident medication charts include a current photograph, or the resident and allergies are recorded.</p> <p>All prescribed 'as required' medications document the indication for use and all medications are administered as prescribed. The corrective actions identified at the previous audit have been addressed.</p> <p>The facility uses a robotically packed medication management system for the packaging of all tablets. The RN on duty reconciles the delivery and documents this. Temperature monitoring of the medication fridges is completed daily with temperatures sighted to be within range.</p> <p>There are no residents self-administering medication currently. A competency to assess the resident's ability to self-administer is available should this be required.</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>PA Moderate</p>	<p>Food is prepared off-site at The Selwyn Foundations' main centralised kitchen. The food services are provided by a contracted catering company. An eight-weekly rolling menu is implemented and changes seasonally. The main kitchen caters for all Selwyn Foundation sites, the village and café. The chefs have completed NZQA modules 167 and 168. Dietitian review of the menu was completed in February 2017. A food safety plan is implemented.</p> <p>The food is transported to the facility in insulated hot boxes and transferred into bain maries. All staff handling food have food handling certificates. Food temperatures are taken before leaving the main kitchen and upon arrival and before service. The receiving kitchen also holds sandwiches, biscuits, soup and fruit which can be utilised for residents over a 24-hour period and supplies are replenished daily.</p>

		<p>There is evidence of modified diets being provided (eg, diabetic, soft and pureed textured meals). Residents with weight loss are reviewed and are given supplements if appropriate. Residents can choose to have breakfast in bed or in the dining room. Staff were observed assisting those residents who require help with food and fluid intake. Lipped plates, sipper cups and adapted cutlery are available and observed in use.</p> <p>The kitchen manager attends the monthly resident meetings and is provided with feedback regarding the meal service. Residents interviewed spoke positively regarding the meal service.</p> <p>A copy of residents' nutritional profiles is not being sent to the main kitchen.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>InterRAI initial assessments and reviews are documented (link 1.3.3.3). Risk assessments have been completed on admission with additional assessments for management of behaviour, pain, wound care, nutrition, depression score, falls and other safety assessments including restraint completed according to need.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	PA Low	<p>Overall the five care plans reviewed described the resident goals, and supports required to meet goals identified through the assessment process (link 1.3.3.3). However, in three of the care plans reviewed, interventions were not all described in sufficient detail to support all needs. There is documented evidence of resident and/or family input ensuring a resident focused approach to care. Residents interviewed confirmed they are involved in the care planning and review process. There is evidence of allied health care professionals involved in the care of the resident. Acute care needs support care plans are documented for short term cares.</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>	FA	<p>Registered nurses (RNs) and caregivers follow the care plan and report progress against the care plan each shift at handover. The handover includes each resident with needs and changes to cares that have occurred. If external nursing or allied health advice is required, the RNs will initiate a referral (eg, to the district nurse or wound care specialist nurse). If external medical advice is required, this will be actioned by the GP. Staff have access to sufficient medical supplies including products to dress wounds. Continence products are available and resident files include a continence assessment and plan as part of the plan of care. Specialist continence advice is available as needed and this could be described.</p> <p>Interventions are described in the care plan (link 1.3.5.2). Activities of daily living and management of skin and wellbeing were well described for the resident, who was identified as being elderly and frail. There were</p>

		<p>strategies documented to support the resident identified as having high falls with these including a sensor mat, hip protectors and management of skin tears. Short-term care plans are used to document short-term cares required.</p> <p>On the day of audit there were eight wounds. There were corrective actions identified at the previous audit with these now addressed. These were as follows: a) There are now two wound care folders in use (one for each wing). There was no evidence of duplicate wound assessments; b) All wounds have been reviewed within the prescribed timeframes; c) Each wound has a separate assessment, plan and review even when one resident may have two wounds. While each wound had a wound assessment plan and evidence of review, there were care plan intervention shortfalls identified (link 1.3.5.2).</p> <p>Interviews with registered nurses and caregivers demonstrated an understanding of the individualised needs of residents. Monitoring charts sighted included behaviour charts, turning charts, food and fluid charts, regular monitoring of bowels and regular (monthly or more frequently if required) weight management. Short-term care plans are used for short-term cares including management of urinary tract and other infections.</p> <p>Many of the residents at Selwyn Kerridge have transferred over from another Selwyn facility. In response to the MOH letter dated 13 November 2018 regarding timely referrals. Files reviewed identified one resident had been referred to the Diabetic Centre Greenlane for an infected callus/diabetes. They had been seen also by the orthotic department and podiatrist and had an ulcer in the past with the wound management plan signed off as closed as healed on 5/3/18. There were detailed interventions around management of the resident's diabetes and details in the long-term care plan around monitoring of blood sugars (documented in medimap) and nutrition with a diabetic management plan in place. Referrals were noted to be completed in a timely manner.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>PA Low</p>	<p>The activity programme confirms that independence is encouraged, and choices are offered to residents. The activity coordinator at Selwyn Kerridge delivers the programme with support from a designated caregiver, while the position of the second activities coordinator is being advertised. The programme runs over seven days per week. The Selwyn Foundation diversional therapist assists with the programming and mentors and supports all activity coordinators and assistants. A wide range of activities, addressing the abilities and needs of residents in the rest home are provided.</p> <p>Activities included physical, mental, spiritual and social aspects of life to improve and maintain residents' wellbeing.</p> <p>On admission, an activity coordinator completes an assessment for each resident and an activity plan is completed. A record is kept of individual resident's activities and progress notes are completed monthly. Reviews are expected to be conducted six-monthly (or earlier should the residents condition determine) as part of the care plan evaluation/review, however these were out of date in files reviewed.</p>

		<p>Residents and family interviews confirmed that the activities are enjoyed, and they are satisfied with the activities programme. Activities include outings as well as community involvement.</p> <p>A monthly meeting is held where residents and relatives have input. Minutes are recorded at the meeting and quality improvements identified and feedback given.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Care plans reviewed have been evaluated by registered nurses six-monthly to assess achievement towards the desired goal, or when changes to care occurred. Acute care plans, for short-term needs, are evaluated and either resolved or added to the long-term care plan as an ongoing need.</p> <p>The family are notified of the outcome of the review by phone call and if unable to attend, they receive a copy of the reviewed plans. There is at least a three-monthly review by the medical practitioner. The family members confirmed they are invited to attend the care plan reviews and GP visits.</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>	FA	<p>The building holds a current warrant of fitness. The building is single storey and divided into two wings. Twenty-four beds in one wing of the service (Banyard wing) are dual-purpose.</p> <p>There are proactive and reactive maintenance management plans in place. Contracted providers test equipment. Electrical testing of non-hard-wired equipment is conducted annually. Medical equipment requiring servicing and calibration is completed annually and is current.</p> <p>There are hazard management systems in place to ensure the physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the residents and any visitors or contractors to the facility. Residents have adequate internal space to meet their needs. External areas are safe and well maintained.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Infection surveillance is part of the infection control programme described in The Selwyn Foundation 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. Three residents who have had infections in the past year had completed forms in their individual record and they were included in infection control data. Acute care needs support care plans are used.</p> <p>Surveillance of all infections is entered on to a monthly infection summary. This data is monitored and evaluated monthly and annually and provided to Selwyn Care head office for benchmarking. Infections are part of the key performance indicators. Outcomes and actions are discussed at quality/staff meetings. If there</p>

		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.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Restraint is described by the restraint coordinator and the care manager as only used where it is clinically indicated, and other de-escalation strategies have been ineffective. Restraint minimisation policies and procedures are comprehensive and include definitions, processes and use of restraints and enablers. There are no enablers or restraint used in the service currently. Staff training is in place around management of any challenging behaviours (link 1.2.7.5).</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p>	PA Low	<p>A complaints register is maintained. There have been eight complaints received in 2018 year-to-date. One of the complaints has been well documented by the new care manager, with evidence of resolution to the satisfaction of the complainant. The care manager is very clear on the process as per policy. Other complaints made in 2018 did not have any documented follow-up, investigation or outcome resolutions. The corrective action identified at the previous audit remains. The risk rating has not been raised as the new care manager was very clear on responsibilities and has already demonstrated that one complaint has been investigated as per policy.</p>	<p>Six of the sixteen complaints made in 2016 did not have any documented follow-up, investigation or outcome resolutions. The risk rating remains as low, as per the previous audit as the care manager has already put a corrective action plan in place to address the issue and has demonstrated through completion of one complaint that they understand and can</p>	<p>Ensure that all complaints have documentation including follow-up letters, investigations and outcome resolutions within the required timeframes.</p> <p>90 days</p>

			implement the policy.	
<p>Criterion 1.2.1.1</p> <p>The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.</p>	PA Low	<p>A strategic plan for 2018 to 2022 has been documented. Review of the 2017 to 2018 plan is not able to be sighted. A business plan has not been documented to date.</p>	<p>A business plan has not been documented for the year July 2018 to June 2019.</p>	<p>Document a business plan for the year July 2018 to June 2019 and monitor progress.</p> <p>90 days</p>
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Moderate	<p>There is an annual training plan in place. There is evidence of training prior to April 2017 and after May 2018. The care manager has provided some clinical training to staff since their appointment, however staff attendances have been low (approximately eight care staff attending most sessions). The care manager has raised a corrective action plan to address the gap in training and is implementing this with a focus on clinical topics.</p> <p>There are a number of Selwyn Care bureau staff and external bureau staff used in the service currently. There is an orientation programme for any new bureau staff member, with this being confirmed as comprehensive by two bureau staff interviewed (one registered nurse and one caregiver). Both described having access to a bureau folder held in the nurses' station that holds key relevant information and both described a three-day orientation programme that included being buddied with a senior staff member prior to them taking on shifts. One resident stated that they had concerns in the past around knowledge of bureau staff, however they confirmed that this had improved lately with staff understanding their needs and being able to provide a high quality of care. A sample of four bureau staff records related to orientation and training were reviewed, and these confirmed that each had been signed off as having completed orientation and required competencies including medication competencies if required. All care staff have not had training that reminds nursing staff of the importance of complete and accurate</p>	<p>Training has not been adequately provided in the 2017 to 2018 year to ensure that staff can provide safe and effective services to residents.</p>	<p>Implement the annual training plan for staff as planned.</p> <p>90 days</p>

		documentation.		
<p>Criterion 1.3.12.3</p> <p>Service providers responsible for medicine management are competent to perform the function for each stage they manage.</p>	<p>PA</p> <p>Moderate</p>	<p>The care manager has identified the issue of medication competencies not being completed annually as required. Training has not been provided in the past year around management and administration of medication.</p>	<p>Medication competencies are not completed annually as per policy. Training has not been provided in the past year around management and administration of medication.</p>	<p>Complete medication competencies and training annually for staff who administer medication.</p> <p>60 days</p>
<p>Criterion 1.3.13.2</p> <p>Consumers who have additional or modified nutritional requirements or special diets have these needs met.</p>	<p>PA</p> <p>Moderate</p>	<p>The resident record includes assessment of each resident's dietary and nutritional needs. The kitchen does not have a copy of the profiles.</p>	<p>The kitchen does not have a copy of the dietary and nutritional needs profiles for each resident.</p>	<p>Ensure that the kitchen has a copy of the dietary and nutritional needs profiles for each resident.</p> <p>60 days</p>
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the</p>	<p>PA</p> <p>Low</p>	<p>The new care manager has identified the lack of six monthly completion of the interRAI assessment and has put a quality improvement plan in place to address this. While all interRAI assessments are now current, five of five did not evidence review at six monthly intervals.</p>	<p>The interRAI reassessment has not been completed six monthly.</p>	<p>Ensure that interRAI reassessments are completed six monthly.</p> <p>180 days</p>

consumer.				
<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>	PA Low	<p>There is documented evidence of resident and/or family input ensuring a resident focused approach to care. Residents confirmed on interview they are involved in the care planning and review process. There is evidence of allied health care professionals involved in the care of the resident. Overall long-term care plans sampled have been reviewed and updated in a timely manner following a decline in health. However, not all care plans included all interventions to support current needs.</p>	<p>(i)One resident with behaviours that challenge does not have individualised strategies documented. (ii) The long-term care plan for one resident did not reference the wound management plan: and (iii) One care plan for a resident with an ulcer referenced the wound but did not reference other factors that would support the healing process eg nutrition or pain management</p>	<p>Ensure that interventions and strategies are comprehensively documented to meet individual needs of the resident</p> <p>90 days</p>
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	PA Low	<p>All residents are assessed at admission and in an ongoing manner to establish interests and skills. A plan is developed for the residents around activities. The activity plans have not been reviewed six monthly or as changes occur.</p>	<p>(i)Activity plans have not been reviewed six monthly or as changes occur for four of the five files reviewed. (ii) Review of the activity plans is not completed in conjunction with the interRAI assessment and review of the care plan.</p>	<p>(i)Review activities plans for residents six monthly or as changes occur. (ii) Review activity plans in conjunction with the interRAI assessment and review of the care plan.</p> <p>180 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.