# Selwyn Care Limited - Selwyn Oaks

## Introduction

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

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

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

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

The specifics of this audit included:

**Legal entity:** Selwyn Care Limited

**Premises audited:** Selwyn Oaks

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

**Dates of audit:** Start date: 26 March 2019 End date: 27 March 2019

**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:** 46

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

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

## General overview of the audit

Selwyn Oaks is owned and operated by Selwyn Care Limited and cares for up to 48 residents requiring rest home and hospital level care. On the day of the audit, there were 46 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 and management.

The service is managed by a registered nurse, village and care manager who has both management and aged care experience. She is supported by an assistant care manager (also a registered nurse). They are supported by a quality manager and operations manager for residential services. Residents, relatives and the GP interviewed spoke positively about the service provided.

The service has exceeded the standard around good practice and activities.

This audit has identified no areas for improvement.

## Consumer rights

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

Policies and procedures adhere with the requirements of the Code of Health and Disability Services Consumers’ Rights (the Code). Residents and families are informed regarding the Code and staff receive ongoing training about the Code.

The personal privacy and values of residents are respected. There is an established Māori health plan in place. Individual care plans reference the cultural needs of residents. Discussions with residents and relatives confirmed that residents and their families are involved in care decisions. Regular contact is maintained with families, including if a resident is involved in an incident or has a change in their current health. Families and friends are able to visit residents at times that meet their needs. Examples of good practice were provided.

There is an established system for the management of complaints, which meets guidelines established by the Health and Disability Commissioner.

## Organisational management

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| --- | --- | --- |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Standards applicable to this service fully attained. |

Services are planned, coordinated and are appropriate to the needs of the residents. The village/care manager is responsible for the day-to-day operations. Goals are documented for the service with evidence of regular reviews. A quality and risk management programme is in place. Data is collected, analysed, discussed and changes made as a result of trend analysis. Quality improvement plans are developed when service shortfalls are identified.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. Ongoing education and training is in place, which includes in-service education and competency assessments.

Registered nursing cover is provided twenty-four hours a day, seven days a week. Residents and families reported that staffing levels are adequate to meet the needs of the residents.

The integrated residents’ files are appropriate to the service type.

## Continuum of service delivery

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| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | All standards applicable to this service fully attained with some standards exceeded. |

There is an admission package available prior to or on entry to the service. Registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family input. Care plans viewed demonstrate service integration and are reviewed at least six monthly. Resident files include medical notes by the contracted general practitioner and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and household leads are responsible for the administration of medicines. Medication charts are reviewed three monthly by the GP.

The diversional therapist, with the assistance of care staff and volunteers, implements the activity programme to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations.

All meals are cooked on site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. Residents commented positively on the meals.

## 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. |

Chemicals are stored safely throughout the facility. Appropriate policies and product safety charts are available. The building holds a current code of compliance. All rooms have ensuites. External areas are safe and well maintained with shade and seating available. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning services are monitored through the internal auditing system. Systems and supplies are in place for essential, emergency and security services.

## Restraint minimisation and safe practice

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| --- | --- | --- |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

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

## Infection prevention and control

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

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

## Summary of attainment

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 2 | 43 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 2 | 91 | 0 | 0 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | Selwyn Care policies and procedures are being implemented that align with the requirements of the Code of Health and Disability Services Consumers’ Rights (the Code). Families and residents are provided with information on admission, which includes information about the Code. Staff receive training around resident rights at orientation and as part of the mandatory training/education programme. Interviews with staff (five care partners [caregivers], two registered nurses, one diversional therapist, the health and safety representative, cook and maintenance person) confirmed their understanding of the Code. Seven residents (five rest home level and two hospital level) and three hospital level relatives interviewed confirmed that staff respect privacy and support residents in making choices. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | The service has in place a policy for informed consent. Completed resuscitation consent forms were evident on all resident files reviewed (three rest home and four hospital). The facility uses the admission agreement as a general consent. All files sampled had signed admission agreements. Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for entering rooms and personal care. Enduring power of attorney forms were filed in residents’ charts. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Residents interviewed confirmed they are aware of their right to access independent advocacy services. Discussions with relatives confirmed that the service provides opportunities for the family/EPOA to be involved in decisions. The chaplain is identified by staff and residents as an advocate. The resident files include information on residents’ family/whānau and chosen social networks. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. The activities programme includes opportunities to attend events outside of the facility. Residents are supported and encouraged to remain involved in the community. Relatives and friends are encouraged to be involved with the service and care. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The service has a complaints policy that describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission. Interviews with residents and relatives confirmed their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints.  A complaint register includes written and verbal complaints, dates and actions taken. Complaints are being managed in a timely manner, meeting requirements determined by the Health and Disability Commissioner (HDC). A total of 30 complaints were received over 2018; all document follow-up and responses to complainants. There have been nine complaints year to date for 2019. Complaints for 2019 have been followed up in a timely manner and document complainants have been satisfied with the outcome. Facility meetings document that complaints are followed up with staff and this was evidenced with a spike on complaints about call bells; facility meetings document discussion with staff as well as individual staff follow-up for specific complaints.  The village/care manager has an open-door policy and always documents all complaints to use as learning experiences for staff. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | There is an information pack given to prospective residents and families that includes information about the Code and the Nationwide Advocacy Service. There is the opportunity to discuss aspects of the Code during the admission process. Residents and relatives interviewed confirmed that information had been provided to them around the Code. Large print posters of the Code and advocacy information are displayed throughout the facility. A manager discusses the information pack with residents/relatives on admission. Families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | A tour of the premises confirmed that the household model of care and design of the households, supports personal privacy for residents. Staff were observed to be respectful of residents’ privacy by knocking on doors prior to entering resident rooms. Staff can describe definitions around abuse and neglect that aligned with policy. Residents and relatives interviewed confirmed that staff demonstrate sensitivity in regard to resident privacy and dignity and where possible, encourage the resident to be involved in their care according to their ability.  The service has a philosophy that promotes quality of life and involves residents in decisions about their care, the service has implemented the Selwyn household model of care over the last year since they moved into the new facility. Resident preferences are identified during the admission and care planning process and this includes family involvement. Interviews with residents confirmed their values and beliefs were considered. Interviews with caregivers described how choice is incorporated into resident cares. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | The Māori health plan policy for the organisation references local Māori health care providers regionally within New Zealand and provides recognition of Māori values and beliefs. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with local iwi through the chaplaincy service. Cultural needs are addressed in the care plan. One of two residents who identify as Māori confirmed their cultural needs are being met by the service. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | An initial care planning meeting is carried out and the resident and/or whānau as appropriate are invited to be involved. Individual beliefs or values are discussed and incorporated into the care plan. Six-monthly multidisciplinary team meetings occur to assess if needs are being met. Family are invited to attend. Discussions with relatives confirmed that residents’ values and beliefs are considered. Residents interviewed confirmed that staff take into account their values and beliefs. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Staff job descriptions include responsibilities. The monthly combined staff meetings, monthly caregiver meetings, and registered nurse/quality meetings include discussions around professional boundaries and concerns as they arise. Interviews with the managers and care staff confirmed their awareness of professional boundaries. Caregivers are trained to provide a supportive relationship based on the household model of care. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | CI | Evidence-based practice is evident, promoting and encouraging good practice. Registered nursing staff are available seven days a week, 24 hours a day. A house GP visits the facility four hours a week and as needed. The GP practice provides an on-call service. The general practitioner (GP) reviews residents identified as stable every three months, with more frequent visits for those residents whose condition is not deemed stable. The GP interviewed was complimentary of the clinical care and service overall.  The service receives support from the district health board, which includes nurse specialist’s visits. The Selwyn Care physiotherapy services are provided on-site four hours per week. A dietitian visits as required and visits at least two monthly. A podiatrist is on site every six weeks. There is a regular in-service education and training programme for staff. The service has links with the local community and encourages residents to remain independent.  Selwyn Oaks is benchmarked against other Selwyn Care villages. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There is an accident/incident reporting policy to guide staff in their responsibility around open disclosure. Staff are required to record family notification when entering an incident into the system. A sample of ten incident reports reviewed for February met this requirement. Family members interviewed confirmed they are notified following a change of health status of their family member. There is an interpreter policy in place and contact details of interpreters were available. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Selwyn Oaks Village is part of The Selwyn Care Limited Group. The facility is certified to provide rest home and hospital (geriatric and medical) level care for up to 48 residents. All the beds are designated dual-purpose beds. There were 46 residents at the time of audit. This included ten residents at rest home level and 36 at hospital level. All residents were funded through the DHB age-related residential care contract.  Selwyn Oaks has a documented business and quality plan. Stated objectives include providing support for residents, investing in people (staff) and enhancing residents’ lives. The plan links to the household model of care and enrichment of resident’s lives. Selwyn Oaks has fully implemented the household model of care. Annual goals document regular reviews via regular meetings.  Selwyn Oaks is managed by an experienced village/care manager (VCM/registered nurse) who has been in the role since August, when this new facility opened, she has previously managed other Selwyn facilities. She is supported by an assistant care manager (ACM)/registered nurse (RN), who has been in the role since the service opened and has previous experience as a registered nurse at other Selwyn facilities. There is also a regional quality manager who provides support. They are supported by the operations manager.  The village and care manager, and assistant care manager have maintained at least eight hours of professional development activities related to managing an aged care facility. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | The assistant care manager provides cover during the temporary absence of the village manager. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | An established quality and risk management system is embedded into practice. Quality and risk performance is reported across facility meetings and to the quality manager, operations manager and board.  Resident-led resident meetings are monthly and relative meetings are quarterly. Minutes are maintained. Residents and relatives interviewed, stated that they feel very involved in the running of their individual households. The most recent survey indicated a high satisfaction from residents and relatives regarding involvement with the service.  Annual resident and relative surveys are completed with results communicated to residents and staff. The service undertook an additional survey following the move to the new facility. The results included 100% satisfaction for; orientation to the new facility, customer service and level of social interaction.  The service has policies and procedures (standard operating 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.  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. Monitoring includes an implemented internal audit schedule, monthly collation and review of incidents and accidents, infection control and call bell audits. Key performance areas are benchmarked against other Selwyn facilities. Quality improvement plans (QIPs) are developed when service shortfalls are identified, and these are monitored by group office. Results are communicated to staff at the monthly caregivers/quality meetings and RN meetings. Meetings and quality improvement plans reflect actions being implemented and signed off when completed.  Health and safety policies are implemented and monitored by the Health and Safety Committee. The Selwyn Foundation Health and Safety Committee meet on a monthly basis. Risk management, hazard control and emergency policies and procedures are in place. A health and safety representative (the maintenance person) was interviewed about the health and safety programme. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Health and safety meetings are conducted bi-monthly at Selwyn Oaks and include the review of the hazard and risks register.  Falls prevention strategies are in place including (but not limited to): individual and group exercise programme; meeting individual toileting needs; sensor mats; use of perimeter guard mattresses; increased monitoring; identification and meeting of individual needs. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | There is an incident/accident reporting policy that includes definitions and outlines responsibilities including: immediate action, reporting, monitoring, corrective action to minimise and debriefing. Individual incident/accident reports are completed for each incident/accident with immediate action noted and any follow-up action required.  A review of ten incident/accident forms identified that forms are fully completed and include follow-up by a registered nurse, including neurological observations. The ‘village and care manager’ and assistant care manager are involved in the adverse event process. There is a debriefing process for all critical incidents that includes a staff debrief and a review of the incident and report. The ‘village and care manager’ was able to identify situations that would be reported to statutory authorities including (but not limited to): infectious diseases, pressure injuries, serious accidents and unexpected death. Appropriate notification has been made as needed.  The service has critical incident reviews for an outbreak of Norovirus and also following a resident fall resulting in a fractured limb. This process demonstrates that all had a full critical event procedure followed. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | There are comprehensive human resources policies in place. Seven staff files reviewed (three registered nurses, a housekeeper, two caregivers (care partners) and the diversional therapist) included a comprehensive recruitment process including: reference checking, signed employment contracts and job descriptions, completed orientation programmes and annual performance appraisals.  A register of registered nursing staff and other health practitioner practising certificates is maintained. The orientation programme provides new staff with relevant information for safe work practice. There is an implemented annual education and training plan that exceeds eight hours annually. The training records document that training sessions are repeated to allow as many staff as possible to attend. Incidental training is provided according to identified need and at staff request. There is an attendance register for each training session and an individual staff member record of training. The service compliments formal training with a wide variety of competencies for all staff.  Registered nurses are supported to maintain their professional competency. Five of five permanent registered nurses have completed their interRAI training. There are implemented competencies for registered nurses. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | Policy is in place for determining staffing levels and skills mix for safe service delivery.  The service philosophy and facility are based on a household model of care. There are four households at the service; each household accommodates up to 12 residents at rest home and/or hospital level of care. There are two floors and each floor has two households. The staff rostering is by floor (two households) with staff based in either of the households.  The ‘village and care manager’ and assistant care manager (both RNs) both work week days and provide on-call.  Household one has ten hospital and one rest home resident. Household two has eleven hospital and one rest home resident. Staffing for this floor includes;  An RN each shift Monday to Sunday, the night RN also covers households three and four. On the AM shift there are four caregivers (care partners) and a house lead (senior caregiver); PM, three caregivers and a house lead. On the night shift there is one caregiver supporting the RN  Household three has eight hospital and three rest home residents. Household four has seven hospital and five rest home residents. Staffing for this floor includes;  An RN for the AM and PM shift Monday to Sunday. On the AM shift there are two caregivers (care partners) and a house lead. On the PM shift there is one caregiver and a house lead. On night shift there are two caregivers.  Staff also assist between floors as needed. The service has expanded the scope of the RN to decide if additional staff are required each shift with responsibility for arranging this.  Housekeepers, maintenance, administration and activity staff are also rostered.  There are sufficient caregivers rostered on duty each day to support the registered nurses and meet the needs of residents.  Staff were visible and were attending to call bells in a timely manner as confirmed by all residents interviewed. Staff interviewed stated that overall the staffing levels are satisfactory and that the managers provide good support. Residents and family members interviewed reported there are sufficient staff numbers. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access. Entries are legible, dated and signed by the relevant caregiver or nurse including designation. Individual resident files demonstrate service integration. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | There are policies and procedures to safely guide service provision and entry to services including an admission policy. The service has an information pack available for residents/families at entry. The admission agreements reviewed meet the requirements of the ARCC contract. Exclusions from the service are included in the admission agreement. Seven admission agreements sighted were signed and dated. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | Policy describes guidelines for death, discharge, transfer, documentation and follow up. A record of transfer documentation is kept on the resident’s file. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities and communication with family is made. The facility uses the yellow envelope system. On the second day of audit a resident was transferred to the DHB. All relevant information went with the resident. The ambulance officer stated that the resident’s care was timely and appropriate. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There was one resident self-administering on the day of audit. There are no standing orders in use. There are no vaccines stored on site.  The facility uses an electronic and robotic pack system. Medications are checked on arrival and any pharmacy errors are recorded and fed back to the supplying pharmacy. Medications are administered by the RN or senior medication competent house leaders. Medication education has been completed in the last year. The medication fridge temperature is checked weekly. Eye drops are dated once opened.  Staff sign for the administration of medications electronically. Fourteen medication charts were reviewed. Medications are reviewed at least three monthly by the GP. There was photo identification and allergy status recorded. ‘As required’ medications had indications for use charted. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The service has one chef manager who works Monday to Friday 7.15 am-4.45 pm and one cook who works weekends 8.00 am-5.30 pm. There are three kitchenhands on each morning shift. All have current food safety certificates. The chef manager oversees the procurement of the food and management of the kitchen. There is a well-equipped kitchen and all meals are cooked on site. Meals are served in the dining rooms from hot boxes. Meals going to rooms on trays have covers to keep the food warm. Special equipment such as lipped plates is available. On the first day of audit meals were observed to be hot and well-presented and residents stated that they were enjoying their meal. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures are monitored and recorded daily. Food temperatures are checked, and these were all within safe limits. The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review. Changes to residents’ dietary needs have been communicated to the kitchen. Special diets and likes and dislikes were noted in a folder. The eight-weekly menu cycle is approved by a dietitian. All residents and family members interviewed were satisfied with the meals.  The food control plan expires 7 April 2019. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | The service records the reason for declining service entry to potential residents should this occur and communicates this to potential residents/family. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. InterRAI assessments had been completed for all seven residents whose files were sampled. Other assessment tools in use were falls risk, pressure injury risk, nutrition and continence. Care plans sampled were developed on the basis of these assessments. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans reviewed were resident-centred. Interventions documented support needs and provide detail to guide care. Short-term care plans are in use for changes in health status. Residents and relatives interviewed stated that they were involved in the care planning process. There was evidence of service integration with documented input from a range of specialist care professionals including the podiatrist, dietitian and mental health care team for older people. The care staff interviewed advised that the care plans were easy to follow, and guidelines were clear. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | When a resident’s condition changes the registered nurse initiates a GP consultation. Staff stated that they notify family members about any changes in their relative’s health status and this was confirmed by family members interviewed. All care plans sampled had interventions documented to meet the needs of the resident. Care plans have been updated as residents’ needs changed.  Resident falls are logged on the computer, documented on accident forms and written in the progress notes. Neurological observations are completed for unwitnessed falls or falls where residents hit their heads.  Care staff interviewed stated there are adequate clinical supplies and equipment provided including continence and wound care supplies.  Wound assessment, wound management and evaluation forms are in place for all wounds. Wound monitoring occurs as planned. There is currently one wound being treated. There is one stage two pressure injury. There are photos of this, and it has been seen by the GP and an incident form has been documented.  Monitoring forms are in use as applicable such as weight, vital signs and wounds. Behaviour charts are available for any residents that exhibit challenging behaviours. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | CI | There is a diversional therapist who oversees the activities programme. She works 40 hours a week Monday to Friday. There are often volunteers who come in at weekends and the diversional therapist leaves activities for the house leads to run. On the day of audit residents were observed doing exercises, playing cards listening to a visiting choir and taking part in a quiz.  There is a weekly programme in large print on noticeboards and whiteboards in the lounges and hallways. Residents have the choice of a variety of activities in which to participate, and every effort is made to ensure activities are meaningful and tailored to residents’ needs. Following the move into the new build where the household model of care is practised, the facility has worked hard developing a more engaging and enriching experience for the residents in their care.  Those residents who prefer to stay in their room or who need individual attention have one-on-one visits to check if there is anything they need and to have a chat. There is a volunteer roster and volunteers often chat one-on-one to residents.  The facility has a chaplain who works three days a week and there is a church service every Sunday at 2.00 pm. She also has meditation sessions every Friday morning. Catholic lay volunteers give communion to Catholics every Tuesday.  There are van outings twice weekly. Sometimes there are shopping trips or visits to cafes for more able residents. There are regular entertainers who visit the facility. Special events like birthdays, Easter, Mothers’ Day, Anzac Day, the Melbourne Cup and Valentine’s Day are celebrated.  A pet therapy team visits monthly.  There is community input from pre-schools, schools, Brownies and Girl Guides.  Residents have an activity assessment completed over the first few weeks following admission that describes the residents past hobbies and present interests, career and family. Resident files reviewed identified that the activity plan is based on this assessment. Activity plans are evaluated at least six monthly at the same time as the review of the long-term care plan. Resident meetings are held monthly. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The seven long-term care plans reviewed had been evaluated by the registered nurse six monthly or when changes to care occurs. Short-term care plans for short-term needs are evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. Activities plans are in place for each of the residents, and these are also evaluated six monthly. The multidisciplinary review involves the RN, diversional therapist and resident/family if they wish to attend. There are three monthly reviews by the GP for all residents. The family member interviewed confirmed that they are informed of any changes to the care plan. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where residents had been referred to the wound care nurse specialist, the dietitian and mental health services for older people. Discussion with the registered nurse identified that the service has access to a wide range of support either through the GP, specialists and allied health services as required. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer’s labels and stored in locked areas. Safety data sheets and product sheets are available. Sharps containers are available and meet the hazardous substances regulations for containers. The hazard register identifies hazardous substances and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff. A spills kit is available. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building holds a current code of compliance dated 29 August 2018. There is a maintenance person on site for 40 hours a week. There is an assistant maintenance/garden person who works 20 hours a week. Contractors are used when required.  Electrical equipment has been tested and tagged. Hoists are checked six monthly and the scales are checked annually. Hot water temperatures have been monitored randomly in resident areas and were within the acceptable range. The communal lounges and hallways are carpeted. The utility areas such as the kitchen and sluice room have vinyl flooring. Residents’ rooms are carpeted but ensuites have nonslip vinyl flooring. All corridors have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained. All outdoor areas have seating and shade. One outside area off a lower deck is not safely fenced. This is currently being fixed. Meanwhile access to this deck is blocked and the high risk is noted in the hazards register.  Caregivers interviewed stated they have adequate equipment to safely deliver care for rest home and hospital level of care residents. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | All rooms have ensuites. Fixtures, fittings and flooring are appropriate. The ensuite facilities are easy to clean. There is ample space in the ensuites to accommodate shower chair/hoists if required. There are privacy signs on all communal toilet doors. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | All rooms are single. There is sufficient space to allow care to be provided and for the safe use of mobility equipment. Staff interviewed reported that they have more than adequate space to provide care to residents. Residents are encouraged to personalise their bedrooms as viewed on the day of audit. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | The facility practices the household model of care. There are twelve rooms in each household and these are built around a large communal lounge and dining room. There is also a smaller ‘den’ (lounge) in each household where residents who prefer quieter activities or visitors may sit. There are toys for visiting children in each ‘den’. There is also a fold down bed for family who need to stay overnight. There is a large activities room, but activities can also take place in the large lounges. There is also a craft room. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | All laundry is done off-site. There is a small personal laundry where residents who like to do their own laundry may do so. There is a cleaning manual. Cleaning services are monitored through the internal auditing system. The cleaner’s equipment was attended at all times or locked away. All cleaning chemicals were labelled. There are two sluice rooms. Disposal of waste water occurs here. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | The documented emergency/civil defence management plan complies with all applicable statutory requirements. The service has an approved evacuation plan. The last fire evacuation drill was held December 2018. The trial evacuation report letter was sighted. Staff attendance is recorded in the training records.  Civil defence equipment and resources are available, and this was discussed with the village and care manager. The facility has back-up lighting, power and sufficient food, water and personal supplies to provide for its maximum number of residents in the event of a power outage/civil defence emergency. A gas barbeque is also available.  Staff are responsible for checking the facility for security purposes on the afternoon and night shifts. There is a security firm patrol each night; External lighting and security systems are adequate for safety and security.  The nurse call system is appropriate for the size of the facility and call bells are accessible in rooms, communal showers and toilets.  There is a minimum of one person who is available 24 hours a day, seven days a week with a current first aid/CPR certificate. The person who drives the van also has a current first aid certificate. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All bedrooms and communal areas have ample natural light and ventilation. All heating is electrical and under-floor. Staff and residents interviewed stated that this is effective. There is an outdoor smoking area. All other areas are smoke free. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | Selwyn Oaks has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system and the Selwyn key performance indicators. A registered nurse is the designated infection control nurse. Minutes are available for staff. Audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. A Norovirus outbreak during February 2019 was appropriately managed. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | A registered nurse at Selwyn Oaks is the designated infection control (IC) nurse. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse and IC team have good external support from the local laboratory infection control team and IC nurse specialist at the DHB. The infection control team is representative of the facility. Infection prevention and control is included as part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | There are organisational infection control policies and procedures appropriate for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies were developed by the Selwyn clinical governance and have been reviewed and updated. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred. The infection control nurse has completed infection control training through the Selwyn infection control coordinators bi-annual meeting/training days. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Infection surveillance is an integral part of the infection control programme and is described in Selwyn’s infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow-up, review and resolution. Short-term care plans are used. Surveillance of all infections is entered on to a monthly infection summary. This data is monitored and evaluated monthly and annually and provided to Selwyn head office for benchmarking. Infections are part of the key performance indicators. Outcomes and actions are discussed at quality/staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. Restraint minimisation policies and procedures are comprehensive and include definitions, processes and use of restraints and enablers.  There were no residents using enablers and no residents with restraints during the audit.  Staff training is in place around restraint minimisation and enablers, falls prevention and management of challenging behaviours. |

# 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.

|  |
| --- |
| No data to display |

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

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

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

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 1.1.8.1  The service provides an environment that encourages good practice, which should include evidence-based practice. | CI | The service built a purpose-built facility and planned to move existing residents from the old facility to the new. To ensure that residents had a smooth transition into the new care home, there was a working group put together to plan a suitable process about six months before the move. The aim was to minimise or prevent any anxiety or distress may cause residents and their families and ensure everyone has a positive experience.  Monthly information and update sessions with residents and families on the new care home and The Selwyn Way were implemented. Residents were involved in choosing colours for furniture. There was a planned resident orientation and practice runs (meal services, getting rooms ready, lots of visits) in the new care home prior to the opening date and residents moving in. Therefore, residents, family and staff were able to take belongings into the new build and set the room up before the day of the move. A counsellor was provided on site to help both residents and staff adapt to the new environment before and after the move.  Residents and their families were allowed to choose which household they would like to be in (based on location within building) and also if there were any particular companions that they would like to be with. | The process ensured that residents and their relatives were kept informed and supported, and also allowed for both resident engagement and participation, the opportunity of maintaining established friendships to promote continued relationships was enhanced. A survey was completed post move, which demonstrated that the move was a positive experience and family and residents felt an improvement in resident’s quality of life since the move into the new care home. |
| Criterion 1.3.7.1  Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | CI | Part of Selwyn Oaks philosophy is enriching residents lives daily and they say it is crucial to do this effectively, listening to the residents and tailoring enrichment/engagement plans to suit their needs. Between March-June 2018 a training programme was developed around developing staff knowledge and understanding about enrichment. It was explained that activities should not be meaningless or done just for the purpose of it but should be resident directed, resident specific and centred around the interests of residents. | Household enrichment plans were developed instead of the previous one plan for all households. The residents within each household are consulted and the enrichment programme designed to suit their needs and interests. Having four enrichment plans rather than one means that the needs of residents are met. A folder on how to organise enrichment sessions in the household was created for each household with step by step guidelines. This has been very useful for staff.  All staff also had a one-on-one training with the diversional therapist going through basic information such as how to use the DVD, TV etc, how to organise and encourage residents to participate in a game, how to organise van outings and how to record enrichment activity in a resident’s Leecare documentation.  The diversional therapist also had a drive to obtain more volunteers to assist household staff with the engagement programme and this has been very successful.  A residents’ activities survey was undertaken in September 2018. For the question please rate the variety of activities available - 90% answered good or very good. For the question - is there enough time to complete activities 90% said yes. Residents also responded with ideas on how the programme could be improved. The diversional therapist followed up on these. She also followed up on the 10% who answered fair. There has also been positive feedback from relatives/friends. |

End of the report.