Selwyn Care Limited - Selwyn Sprott Village

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Selwyn Care Limited
Premises audited:	Selwyn Sprott Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 30 July 2019 End date: 31 July 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: 84

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 Sprott is part of The Selwyn Foundation Group. The facility is certified to provide rest home and hospital (geriatric and medical) and dementia level care for up to 97 residents. Seventy-three beds are dual-purpose rooms and twenty-four are dementia care beds. On the days of audit there were 84 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 residents and staff files, observations and interviews with residents, staff, management and the general practitioner.

Selwyn Sprott has a fully implemented quality and risk system. The service is managed by an experienced 'village and care' manager who previously worked as a clinical manager at Sprott House for 14 years. She is supported by two senior registered nurses and a lifestyle support manager. Residents and family interviewed spoke positively about the service provided.

This audit identified an improvement needed around neurological observations.

Consumer rights

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

Policies and procedures adhere with the requirements of the Code of Health and Disability Services Consumers' Rights (the Code). Residents and families are informed regarding the Code and staff 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

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.

Services are planned, coordinated and appropriate to the needs of the residents. The village and care manager are 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

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.		Standards applicable to this service fully attained.

The village and care manager take primary responsibility for managing entry to the service with assistance from the senior RNs. Comprehensive service information is available. Initial assessments are completed by a registered nurse, including interRAI assessments. The registered nurses complete care plans. Residents interviewed confirmed they were involved in the care planning and review process.

Each resident has access to an individual and group activities programme. The group programme is varied and interesting.

Medicines are stored and managed appropriately in line with legislation and guidelines. General practitioners review residents at least three monthly or more frequently if needed.

Meals are prepared on site under the direction of a dietitian. The menu is varied and appropriate. Individual and special dietary needs are catered for. Residents interviewed were complimentary about the food service.

Safe and appropriate environment

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

The building has a current warrant of fitness and emergency evacuation plan. Ongoing maintenance issues are addressed. Chemicals are stored safely throughout the facility. There is sufficient space to allow the movement of residents around the facility using mobility aids. There are several lounge and dining areas throughout the facility. The internal areas are able to be ventilated and heated. The outdoor areas are safe and easily accessible. Cleaning and maintenance staff are providing appropriate services. Staff have planned and implemented strategies for emergency management. Emergency systems are in place in the event of a fire or external disaster. There is a first aider on duty at all times.

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.

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. Five residents were using restraints and four residents were using enablers at the time of audit.

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.

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	0	49	0	0	1	0	0
Criteria	0	100	0	0	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The Selwyn Foundation 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 six-monthly mandatory training/education programme. Interviews with care staff (ten caregivers, five registered nurses (RNs) and one lifestyle support manager) confirmed their understanding of the Code. Six residents (two rest home level and four hospital level) and four relatives (two hospital level, and two dementia) interviewed, confirmed that staff respect privacy and support residents in making choices.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	The service has policies and procedures relating to informed consent and advanced directives. All ten resident files reviewed included signed informed consent forms and advanced directive instructions. Staff are aware of advanced directives. For those residents who are not mentally competent to make a decision regarding resuscitation and no previous resuscitation instructions are in place, there is evidence of GP discussion with family and a medical decision regarding resuscitation status is documented by the GP. Enduring power of attorney evidence is sought prior to admission and activation documentation is obtained and both are filed in resident file.

		Admission agreements are in place for all residents, all are signed by the resident or nominated representative. Discussion with residents and families identified that the service actively involves them in decision making.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Residents interviewed confirmed they are aware of their right to access independent advocacy services. Discussions with relatives confirmed 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. A total of eleven complaints were received from October 2018 to present date. There were no trends identified. Complaints are being managed in a timely manner, meeting requirements determined by the Health and Disability Commissioner (HDC). There is evidence of lodged complaints being discussed in management and staff meetings. All complaints received have been documented as resolved with appropriate corrective actions implemented.
Standard 1.1.2: Consumer Rights During Service Delivery	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

Consumers are informed of their rights.		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 there are areas that support personal privacy for residents. Staff were observed to be respectful of residents' privacy by knocking on doors prior to entering resident rooms. Staff could describe definitions around abuse and neglect that 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. 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 disability and other community representative groups as requested by the resident/family. Cultural needs are addressed in the care plan. The Māori assessment and care plan reflected the residents' cultural needs. One resident who identified 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,	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 plans. Annual 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 consider their values and beliefs.

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 full facility meetings include discussions around professional boundaries and concerns as they arise. Management provided guidelines and examples of mentoring for specific situations. Interviews with the managers and care staff confirmed their awareness of professional boundaries. Caregivers are trained to provide a supportive relationship based on sense of trust, security and self-esteem. Caregivers from the dementia unit described how they build a supportive relationship with each resident. Interviews with two families from the dementia unit confirmed the staff assist to relieve resident's anxiety.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	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 five days a week and provides an after-hours 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 is satisfied with the level of care that is being provided. The service receives support from the district health board, which includes nurse specialist visits. Physiotherapy services are provided by two registered physiotherapists twice a week for on-site six hours per week. A dietitian is also available for urgent consultations. 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 Sprott is benchmarked against other villages within the Selwyn Foundation. If the results are above the benchmark, a quality improvement plan is developed by the service.
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. All 15 incident reports reviewed for June and July 2019 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	FA	Selwyn Sprott is part of The Selwyn Foundation Group. The facility is certified to provide rest home and hospital (geriatric and medical) and dementia level care for up to 97 residents. Seventy-three beds are dual purpose rest home or hospital and twenty-four to dementia. On the

ensures services are planned, coordinated, and appropriate to the needs of consumers.		days of audit there were 84 residents. Thirty-two residents were receiving rest home level care (including one on an LTS-CHC and two respite residents) and twenty-eight were receiving hospital (including two on an LTS-CHC contract) level care and twenty-four residents in the secure dementia unit. All other residents were on the age-related care contract (ARCC). The Selwyn Foundation has owned Selwyn Sprott Village since October 2018. The Selwyn Foundation has an overarching five-year strategic plan 2018 to 2022 which includes the model of care 'The Selwyn Way' which underpins how the Selwyn Foundation provides services within the context of its mission. The strategic plan also includes the organisational goals, and these are reflected in the 2019-2020 Selwyn Sprott business plan, which describes the vision, values and objectives of Selwyn Sprott. Annual goals are linked to the business plan and reflect regular reviews via regular meetings. Selwyn Sprott is managed by an experienced 'village and care' manager who previously worked as a clinical manager at Sprott House for 14 years with a break of one year before returning in January 2019 as 'village and care' manager. She is supported by two senior registered nurses, a lifestyle support manager (occupational therapist), who has been in the role for nine years and manages the dementia unit. They are supported by the group regional clinical quality manager and the operations manager. The 'village and care' manager has 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 lifestyle support manager and senior registered nurses cover during the temporary absence of the 'village and care 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	FA	An established quality and risk management system is embedded into practice. Quality and risk performance are reported across facility meetings and to the group operational and clinical and quality manager. Discussions with the managers (group operations manager, regional clinical quality manager, village and care manager and lifestyle support manager), the GP and staff reflects staff involvement in quality and risk management processes. Resident meetings are monthly. Minutes are maintained. Annual resident and relative surveys

principles.		are completed with results communicated to residents and staff. A Selwyn Foundation communication resident/relative survey was distributed in April 2019 to gain an understanding of the communication levels within Selwyn Sprott. Following feedback from the survey, quality improvements have been implemented around communication with family/residents and the activity programme. 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. The quality monitoring programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation. There are clear guidelines and templates for reporting. The facility has implemented established processes to collect, analyse and evaluate data. This is utilised for service improvements. Key performance areas are benchmarked against other Selwyn facilities. Quality improvement plans (QIPs) are developed when service shortfalls are identified, and these are monitored by group office. Results are communicated to staff at the monthly staff/quality meetings and reflect actions being implemented and signed off when completed. Health and safety policies are implemented and monitored by the Health and Safety Committee. The Selwyn Sprott 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 (cleaner) were interviewed about the health and safety programme. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Falls prevention strategies are in place including (but not limited to): 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	PA Moderate	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 15 incident/accident forms (a sample from June and July 2019) identifies that forms

consumers and where appropriate their family/whānau of choice in an open manner.		are fully completed and include follow-up by a registered nurse. However, neurological observations were not evidenced to be consistently completed for unwitnessed falls as per policy. The village and care manager and senior registered nurses 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 at the Clinical Governance Group. The group operations manager and village and care manager were 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. There have been no infectious outbreaks since October 2018.
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. Nine staff files reviewed (the village and care manager, lifestyle support manager, one senior registered nurse, one registered nurse, a housekeeper, maintenance assistant, activities coordinator and two caregivers) 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 Selwyn Foundation have an online interactive video and quiz training programme known as Selwyn Learn which has been introduced at Sprott Village. The training plan is implemented using a mixture of Selwyn Learn and on-site trainings. Two subjects a month are made available to staff with a requirement to correctly answer the online quiz. If staff do pass one of the three attempts, the educator completes a one-on-one education session with the employee within one month of the training date. 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. There are thirteen staff who regularly work in the dementia unit. Nine staff have completed the required NZQA dementia education modules and four staff who have been employed in the last six months, are enrolled in the dementia programme through the New Zealand Tertiary college. Registered nurses are supported to maintain their professional competency. Eight of nine 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	A policy is in place for determining staffing levels and skills mix for safe service delivery. Two senior registered nurses are rostered from 9 am to 5.30 pm in both the North and the West wings. In both the North and West dual-purpose wing, a registered nurse is on duty morning and afternoon shifts. One RN is rostered on across the facility at night. The dual-purpose North wing has 13 hospital residents and 18 rest home residents. On morning shift there are five caregivers (three long and two short). On afternoon there are five caregivers (three long and two short) and on nightshift there are two caregivers rostered the full shift. The dual-purpose West wing has 15 hospital residents and 14 rest home residents. On morning shift there are six caregivers (four long and two short). On afternoon there are four caregivers (two long and two short) and on nightshift there are two caregivers rostered the full shift. The dementia wing has 24 residents. The lifestyle support manager (OT) is based in the dementia unit. An RN is rostered three days a week. On morning shift there is a senior caregiver/team leader rostered for the full shift and three caregivers (two long and one short). A caregiver/team leader rostered on afternoon shift is supported by three caregivers (two long and one short). There are sufficient caregivers rostered on duty each day to support the registered nurses and meet the needs of residents. There is a pool of Selwyn casuals available to assist and an agency are used as required. 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	The service has admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. Written information on the service philosophy and practices particular to dementia care are included in the information pack. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the village and care manager and/or senior registered nurses.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. Relatives are notified if transfers occur.
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	Twenty medication files were sampled from across each of the three levels of care including two respite residents. The service has implemented an electronic medication system for long-term residents and paper-based for the respite residents. The medication management policies comply with medication legislation and guidelines. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Resident's medicines are stored securely in the medication room/cupboards in each of the three areas (rest home, hospital and dementia). Medication administration practice complies with the medication management policy for a medication round in each of the areas observed. Registered nurses and caregivers administer medicines. All staff that administers medicines are competent and have received medication management training. The facility uses a pre-packaged medication management system for the packaging of all tablets. The RN on duty reconciles the delivery and documents this. Medical practitioners write medication charts correctly and there was evidence of three-monthly reviews by the GP. There were four residents self-administering medicines at the time of audit; each resident has a secure storage area; all had a documented assessment and consent and three-monthly reviews. The RN explained how they check administration daily.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this	FA	There is a fully functional kitchen and all food is cooked on site by an externally contracted service provider. There is a food services manual in place to guide staff. There is a verified food control plan which expires July 2020 and on the day of audit temperature monitoring schedules and cleaning schedules were consistently completed.

service is a component of service delivery.		A resident nutritional profile is developed for each resident on admission and provided to the kitchen staff. This document is reviewed at least six monthly as part of the care plan review. The kitchen is able to meet the needs of residents who require special diets and the kitchen manager works closely with the RNs on duty. There was evidence that there are additional nutritious snacks available over the 24-hour period in the secure dementia unit. Mealtimes observed in all units evidenced that staff were always available to assist and support residents. All kitchen staff have completed food safety training. The kitchen follows a rotating seasonal menu, which has been reviewed by the contractor's dietitian. There is special equipment available for residents if required. All food is stored appropriately. Residents and the family members interviewed were very happy with the quality and variety of food served.
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 reasons for declining service entry to residents should this occur and communicates this decision to residents/family/whānau and the referring agency. Anyone declined entry is referred back to the referring agency for appropriate placement and advice. Information on alternate placement options is given out.
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. The interRAI assessment tool is implemented and additional paper-based assessments as needed such as continence, dietary profile and pain. The interRAI and paper-based assessments formed the basis of care plans.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The long-term care plans reviewed were all paper-based, the service will transfer to a computer-based care plan system post audit. Care plans described the support required to meet the resident's goals and needs. There was evidence of allied health care involvement in the resident files reviewed including a dietitian, speech and language therapist, podiatrist and wound care specialists. Residents and their family interviewed, reported that they are involved in the care planning and review process. Short-term care plans were in use for changes in health status. Staff interviewed reported they found the care plans easy to follow and were well informed

		regarding resident needs.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Registered nurses (RNs) and caregivers follow the care plan and report progress against the care plan each shift at handover. If external nursing or allied health advice is required, the RNs will initiate a referral (eg, to the district nurse, hospice nurse and wound care specialist nurse). If external medical advice is required, this will be actioned by the GPs. Staff have access to sufficient medical supplies. Sufficient 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. Wound assessment, monitoring and wound management plans were in place for all identified wounds. There were nine wounds on the day of audit including one hospital resident with a stage two facility acquired pressure injury. All wounds have been reviewed in appropriate timeframes. The RNs have access to specialist nursing wound care management advice through the district nursing service. Interviews with registered nurses and caregivers demonstrated an understanding of the individualised needs of residents. There was evidence of pressure injury prevention interventions such as two hourly turning charts, food and fluid charts, regular monitoring of bowels and regular (monthly or more frequently if required) weighs. Monitoring charts had been consistently documented. The GP praised the service and the care provided.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	The service employs a lifestyle support manager who is also an occupational therapist who along with a team of two activity staff provide activities for all areas over seven days a week. There is a set activity programme for the facility and specific dementia activity plan. The overall activity plan is resident-focused and is planned around meaningful everyday activities and includes a wide range of activities including themed days, clubs, community visits, happy hours and physical activity. All residents can join in any activity including the resident from the dementia unit. Programmes delivered are appropriate to the setting, for example there are more sensory activities for the very high needs residents who are less able to join in. There is evidence that the residents have regular input into the activity programme. The activity support manager and her team chat to residents every day about activities and encourage them to join in. The residents were observed enjoying activities on the day of audits, including a school group visiting in the dementia unit. An activity profile is completed on admission in consultation with the resident/family (as

		appropriate). Residents in the dementia unit have an activity plan over 24 hours. Relatives interviewed advised that the activity programme was interesting with lots of choice and the residents were encouraged to participate. In the files reviewed the recreational plans had been reviewed six monthly at the same time as the care plans were reviewed. Activity participation was noted in the progress notes.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	The registered nurses evaluate all initial care plans within three weeks of admission. The paper-based files all documented historical, six-monthly written evaluations of care. There was at least a three-monthly review by the GP. Reassessments have been completed using interRAI for all residents who have had a significant change in health status. The RN completing the plan signs care plan reviews. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files sampled.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The RNs initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family, as evidenced in medical notes. The staff provided examples of where a resident's condition had changed, and the resident was reassessed.
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 implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons and goggles are available, and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals sighted were labelled correctly and were all stored safely throughout the facility. Safety data sheets are available.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical	FA	The building has a current building warrant of fitness, which expires in July 2020. A maintenance person undertakes the reactive maintenance and works 40 hours per week. All medical and electrical equipment was recently serviced and/or calibrated. Hot water temperatures are

environment and facilities that are fit for their purpose.		monitored and managed within 43-45 degrees Celsius. The service has two floors for the West wing, each floor has a lounge and dining area, there are stairs and a lift between floors The dementia unit and also the North wing are single story, and both have a large dining and lounge area. The facility has sufficient space for residents to mobilise using mobility aids. External areas are maintained. Residents have access to safely designed external areas that have shade. Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans. The dementia area is secure. It has secure garden areas that are easy to access, and the unit is well maintained. There are also quiet low stimulus areas that provide privacy when required.
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	There are an adequate number of toilets and shower/bathing areas for residents and separate toilets for staff and visitors. Some bedrooms have ensuites and other residents share communal toilets and showers. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	All resident's rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	There is a large central dining room for each of the wings in the rest home and hospital. There are several sitting areas in the hospital and rest home. The dementia unit has one large lounge and dining area and smaller sunny sitting areas. There is adequate space throughout the facility to allow maximum freedom of movement while promoting safety for those that wander. There is adequate space to allow for group and individual activities.

Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	There are dedicated cleaning staff to clean the facility. Staff have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme. Residents interviewed were satisfied with the standard of cleanliness in the facility. Laundry staff complete all laundry on site for both this facility and another. The laundry is large and well maintained. Residents interviewed were satisfied with the laundry service.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Six monthly fire evacuation practice documentation was sighted. A contracted service provides checking of all facility equipment including fire equipment. Fire training and security situations are part of orientation of new staff and include competency assessments. Emergency equipment is available at the facility. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas cooking. Short-term back-up power for emergency lighting is in place. A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available at all times. Activities staff also hold first aid certificates. Call bells were situated in all communal areas, toilets, bathrooms and personal bedrooms. Residents were sighted to have call bells within reach during the audit. Where appropriate, sensor mats were also observed to be in use. The service has a visitor's book at reception for all visitors including contractors to sign in and out. Appropriate security systems are in place.
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	General living areas and all resident rooms are appropriately heated and ventilated. All rooms have external windows that open, allowing plenty of natural sunlight.
Standard 3.1: Infection control management	FA	Selwyn Sprott 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

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.		service. It is linked into the incident reporting system and the Selwyn key performance indicators. A registered nurse is the designated infection control nurse with support from the assistant care lead and the infection control team. Minutes are available for staff. Audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation.
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 Sprott 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 coordinator and IC team (includes H & S team members and RNs) have good external support from the local laboratory infection control team, IC nurse specialist at the DHB and Bug Control. 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 Selwyn Foundation infection control policies and procedures appropriate for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies were developed by the Selwyn clinical governance and have been reviewed and updated.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred. The infection control coordinator has completed infection control training through the local DHB and Bug Control. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.

Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Infection surveillance is an integral part of the infection control programme and is described in Selwyn's infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow-up, review and resolution. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually and provided to Selwyn head office for benchmarking. Infections are part of the key performance indicators. Outcomes and actions are discussed at clinical and staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible. There have been no outbreaks since the previous audit.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Restraint practices are only used where it is clinically indicated and 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. Selwyn Sprott is actively working on reducing restraint and staff interviewed were engaged in meeting this goal. There were four residents using enablers (bedrails) and five hospital residents with restraints (bedrails) during the audit. Staff training is in place around restraint minimisation and enablers, falls prevention and management of challenging behaviours.
Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.	FA	The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator (a registered nurse) and for staff are documented and understood. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements.
Standard 2.2.2: Assessment Services shall ensure rigorous	FA	A restraint assessment tool is completed for residents requiring an approved restraint for safety. Assessments are undertaken by the restraint coordinator in partnership with the RNs, GP, resident

assessment of consumers is undertaken, where indicated, in relation to use of restraint.		and their family/whānau. Restraint assessments are based on information in the care plan, resident/family discussions and observations. Ongoing consultation with the resident and family/whānau are evident. Two hospital level residents' files where restraints are in use, and two hospital level files where enablers were in use were selected for review. The completed assessment considered those listed in 2.2.2.1 (a) - (h).
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint. Restraint authorisation is in consultation/partnership with the resident, family and the GP. The use of restraint is linked to the residents' care plans. Internal restraint audits measure staff compliance in following restraint procedures. Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Monitoring was evidenced to be consistently documented on the two restraint monitoring records reviewed. A restraint register is in place providing an auditable record of restraint use and is completed for all residents requiring restraints and enablers.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations are conducted monthly and restraint use is discussed monthly at registered nurse, staff and quality management meetings. A review of two resident files identifies that evaluations are up to date. The service provided evidence where evaluation of the need for the use of restraint was evaluated and removal of a restraint was trialled successfully for one resident.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The restraint minimisation programme is discussed and reviewed at the annual organisation-wide restraint coordinators meetings, monthly registered nurse meetings, monthly full facility and wing staff meetings. Meeting minutes include (but are not limited to): a review of the residents using restraints or enablers, updates (if any) to the restraint programme and staff education and training.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.4.3 The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.	PA Moderate	Individual incident reports are completed for each incident/accident with immediate action noted. The data is linked to the organisation's benchmarking programme and this is used for comparative purposes. Minutes of the staff meetings reflect a discussion of results. One of ten incident reports for unwitnessed falls evidenced that neurological observations had been fully completed as per policy.	Ten of fifteen incident forms were sampled where the resident had experienced an unwitnessed fall. RN assessment was documented following the incident. Nine neurological observations were not completed when the resident was asleep.	Ensure that neurological observations are recorded for unwitnessed falls as per policy. 60 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.