

Selwyn Care Limited - Sarah Selwyn

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 BSI Group New Zealand Ltd, 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:	Sarah Selwyn
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 25 March 2021 End date: 26 March 2021
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:	78

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
Yellow	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
Red	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

Sarah Selwyn is owned and operated by the Selwyn Foundation and cares for up to 82 residents requiring rest home or hospital level care. On the day of the audit, there were 78 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 care manager is a registered nurse who has been in the role since November 2017. She has nursing experience with the DHB. The care manager is supported in her role by a senior registered nurse who has been in her role for three years, and a regional clinical quality manager/registered nurse. Residents, relatives and the GP interviewed spoke positively about the service provided.

The service has exceeded the standard around quality initiatives and activities.

This audit has identified three areas for improvement around: care plan documentation, care interventions and restraint evaluation.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The service adheres to the Health and Disability Commissioner's Code of Health and Disability Consumers' Rights (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 where appropriate 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 can 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.		Standards applicable to this service fully attained.
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Services are planned, coordinated, and are appropriate to the needs of the residents. The care manager is responsible for day-to-day operations. Goals are documented for the service with evidence of monthly reviews. Quality and risk data is collected, analysed and discussed, and changes made as a result of trend analysis. Corrective actions are implemented and evaluated where opportunities for improvements 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 for staff is implemented and linked to competency assessments.

Registered nursing cover is provided 24 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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Residents are assessed prior to entry to the service. A baseline assessment is completed upon admission and an interRAI assessment within three weeks. Electronic long-term care plans are developed by the service's registered nurses, who also have the responsibility for maintaining and reviewing the support plans.

Assessment tools and monitoring forms are used to assess the level of risk and ongoing support required for residents. Long-term care plans are evaluated six-monthly or more frequently when clinically indicated. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files.

The activity programme is varied and reflects the interests of the residents including community interactions.

There are medication management policies that are comprehensive and direct staff in terms of their responsibilities in each stage of medication management. Competencies are completed. Medication profiles are up to date and reviewed by the general practitioner three-monthly or earlier if necessary.

The menu is designed and reviewed by a registered dietitian. The food service is provided by an external catering company and cooked on site. Residents' individual needs are identified. There is a process in place to ensure changes to residents' dietary needs are communicated to the kitchen. Regular audits of the kitchen occur.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The service displays a current building warrant of fitness. A preventative maintenance schedule is in place that complies with current legislation and includes equipment and electrical checks. This is in addition to a responsive service as matters arise. Outdoor areas are well maintained, and easily accessed by residents with shade and seating available.

Residents' rooms provide single accommodation and are of an appropriate size to allow for care to be provided and for the safe use and manoeuvring of mobility aids. Bathroom and showering facilities are provided throughout the facility and are easily accessible. Fixtures, fittings and flooring are appropriate.

The service has policies and procedures for management of waste and hazardous substances and incidents are reported on in a timely manner. Chemicals are stored safely throughout the facility. There are documented and implemented policies and procedures for cleaning and waste management. Cleaning and laundry services are provided seven days a week by household staff and monitored via the internal audit system. Essential security systems are in place to ensure resident safety with adequate

supplies readily available should a disaster occur. Six monthly trial evacuations are undertaken with associated education on fire and emergency evacuation. There are staff on duty with a current first aid certificate.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Some standards applicable to this service partially attained and of low risk.
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Staff regularly receive 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 who is a registered nurse. Eight residents were using restraints and two residents were using enablers.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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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	1	46	0	2	1	0	0
Criteria	2	96	0	2	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
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Families and residents are provided with information on admission which includes information about the Health and Disability Commissioner's (HDC) Code of Health and Disability Consumers' Rights (the Code). Staff receive training about resident rights at orientation and as part of the annual in-service programme. Interviews with three managers (care manager, regional clinical quality manager, village manager) and eighteen staff (seven caregivers [five AM shift and four PM shift], six registered nurses [RN] [including one senior RN], one kitchen manager, one kitchenhand, one housekeeper, one diversional therapist, one physiotherapist) reflected their understanding of the Code with examples provided of how it is applicable to their job role and responsibilities. Thirteen residents (one rest home, twelve hospital) and four relatives (three hospital, one rest home) interviewed, confirmed that staff respect their privacy and support residents in making choices.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. The resident or their EPOA signs written consents. Advanced directives are signed for separately. There is evidence of discussion with family when the GP completed a clinically indicated not for resuscitation order. Caregivers and the care manager (RN) interviewed, confirmed verbal consent is obtained when delivering care. Discussion with family members identified that the service actively involves them in decisions that affect their relative's lives.</p>

give informed consent.		Nine of nine resident files sampled have a signed admission agreement and consents.
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	Residents interviewed confirmed they are aware of their right to access independent advocacy services. Discussions with relatives confirmed the service provided opportunities for the family/enduring power of attorney (EPOA) to be involved in decisions. A chaplain is identified by staff and residents as an advocate for the residents. The resident files include information on resident's family/whānau and chosen social networks.
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	Residents and 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.
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are made available at reception. Information about complaints is also provided on admission. Interviews with residents and families confirmed their understanding of the complaints process. The care manager was able to describe the process around reporting complaints, which complies with requirements set forth by the Health and Disability Commissioner (HDC).</p> <p>There is a complaint register available. Twenty-one complaints were registered in 2020 and seven complaints have been lodged in 2021 (year-to-date). All seven complaints were reviewed in detail with one complaint received via the Auckland DHB on 1 March 2021. All seven complaints reflected evidence of acknowledgement, a comprehensive investigation and communication with the complainant within the timeframes determined by HDC. Complaints received often result in a corrective action plan (quality improvement project) if opportunities for improvement are identified. Staff are kept informed in meetings, evidenced in meeting minutes. Five of the seven complaints received have been documented as resolved to the complainant's satisfaction. Two remain open, including the complaint received by ADHB. All required documentation has been submitted to the ADHB.</p>
Standard 1.1.2: Consumer Rights	FA	There is an information pack given to prospective residents and families that includes information about the Code and their right to make a complaint. There is the opportunity to discuss aspects of

<p>During Service Delivery</p> <p>Consumers are informed of their rights.</p>		<p>the Code during the admission process. Residents and relatives interviewed confirmed that information is provided to them about the Code. Large print posters of the Code in English and in te reo Māori are displayed in visible locations. The care 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.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>A tour of the premises confirmed there are areas that support personal privacy for residents. Resident rooms are large with ample room for visitors. Staff were observed to be respectful of residents' privacy by knocking on doors prior to entering resident rooms. A light outside the room indicates when cares are being provided. Staff could describe definitions around abuse and neglect that aligned with policy. Residents and relatives interviewed confirmed that staff treat residents with respect.</p> <p>The service philosophy promotes quality of life and involves residents in decisions about their care. Resident preferences are identified during the admission and care planning process and include family involvement. Interviews with residents and family confirmed their values and beliefs were considered. This was also evidenced in the nine residents' files reviewed. Caregivers interviewed could describe how choice is incorporated into resident cares.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The Māori health plan policy for the organisation references local Māori health care providers and provides recognition of Māori values and beliefs. A local kaumātua is available as required. 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 assessed during the admission process and are addressed in the care plan. There was one resident who identified as Māori at the time of the audit who confirmed their individual needs were being met by the service. Staff were observed speaking in te reo Māori to this resident.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and</p>	FA	<p>An initial care planning meeting is carried out where 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 is 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.</p>

respect their ethnic, cultural, spiritual values, and beliefs.		
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Staff job descriptions include responsibilities. The monthly staff meetings include discussions around professional boundaries and concerns as they arise. Minutes are shared with all staff. Interviews with the managers and care staff confirmed their awareness of professional boundaries.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	An in-service online training programme, developed by the Selwyn Foundation, is implemented as per the training plan. All facility staff are accessing the modules in a timely manner and are completing the modules within the required timeframes. In addition, the RNs attend additional external DHB training. The service benchmarks with other Selwyn Foundation services and uses outcomes to improve resident outcomes. Residents' falls are below the Selwyn benchmark with evidence of a drop in the number of falls in 2020 although restraint is in place for a selection of residents who are at risk of falling. The number of pressure injuries has reduced. The facility works in collaboration with the DHB wound care specialist nurses and allied health professionals. There is a minimum of one first aid trained registered nurse on each shift. Residents and family advised that the RNs and caregivers are caring and competent.
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. The sample of adverse events reviewed met this requirement. Family interviewed confirmed they are kept informed following a change of health status of their family member or an adverse event. There is an interpreter policy in place and contact details of interpreters are available. At the time of the audit, there was one resident who spoke only limited English. Family and google translate are used to assist with translation.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and	FA	Sarah Selwyn is a Selwyn Foundation aged care facility situated in the Selwyn Village at Pt Chevalier, Auckland. The facility is certified to provide rest home and hospital (geriatric and medical) level care for up to 82 residents. There were 78 residents living at the facility at the time of the audit (3 rest home level and 75 hospital level). Two residents (hospital) were under the interim care (non-

<p>appropriate to the needs of consumers.</p>		<p>weight bearing) contract and the remaining residents were on the age-residential care contract (ARCC).</p> <p>The service has a business plan, 2020 – 2021 which is reviewed annually. The service has quality improvement plans which have been reviewed and updated regularly.</p> <p>The care manager is a registered nurse who has been in the role since November 2017. She has nursing experience from the DHB. The care manager is supported in her role by a senior registered nurse who has been in her role for three years, and a regional clinical quality manager/registered nurse.</p> <p>The care manager has completed at least eight hours of professional development relating to managing an aged care facility.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>The senior registered nurse covers during the temporary absence of the care manager with additional support available from the regional quality clinical manager/RN.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>Discussions with the care manager and staff reflected their involvement in quality and risk management processes. A documented quality/risk management plan is in place.</p> <p>Resident meetings are led by the diversional therapist and take place monthly. Minutes are maintained. A 2020 resident survey was not completed due to Covid-19. Plans are currently underway to initiate another satisfaction survey in 2021. Two surveys conducted in 2019 (sample 28 and 15 residents respectively) reflected high levels of satisfaction with the services delivered.</p> <p>The service's policies are reviewed at a national level every one-three years with more frequent reviews if changes to policy occur. Staff are required to read and sign that they have read and agree to any policy changes.</p> <p>The quality management programme is overseen by the regional quality clinical manager who was interviewed. The quality monitoring programme is designed to monitor aspects of service delivery. There are clear guidelines and templates for reporting. The facility collects, analyses and evaluates a range of data (eg, falls, infections, pressure injuries, medication errors, restraint use, incidents, skin</p>

		<p>tears). This data is benchmarked against other Selwyn aged care facilities and externally with other large providers of aged care. Results are utilised for service improvements. Internal audits are conducted as per the internal audit schedule. Staff are kept informed via meetings and during handovers.</p> <p>Quality improvement projects (QIPs) are developed where service shortfalls are identified (eg, incidents/accidents, internal audit results, key performance indicator data, complaints received). QIPs are communicated to staff via a range of meetings. QIPs, internal audits and meeting minutes reflect the actions being implemented.</p> <p>Health and safety policies are implemented. A registered nurse is the designated health and safety representative and has attended stage one health and safety training. Risk management, hazard control and emergency policies and procedures are in place. 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. External contractors and new staff undergo health and safety orientation.</p> <p>Falls prevention strategies are in place including (but not limited to): sensor mats, increased monitoring, identification and meeting of individual needs. A physiotherapist is available Monday – Thursday and is assisted by a physiotherapy assistant/senior caregiver.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>There is an incident/accident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise and debriefing. Individual incident/accident reports are completed for each incident/accident with immediate action noted and any follow-up action required.</p> <p>A review of fifteen incident/accident forms (skin tears; witnessed and unwitnessed falls) identified that the incident/accident forms were fully completed and include follow-up by a registered nurse. Missing were neurological observations that followed protocol for two residents who sustained injuries to their head (link 1.3.6.1).</p> <p>The care manager was able to identify situations that would be reported to statutory authorities. There have been no outbreaks since the previous audit. A Section 31 report has been completed for a stage four pressure injury.</p>
<p>Standard 1.2.7: Human Resource</p>	<p>FA</p>	<p>Human resources policies include recruitment, selection, orientation and staff training and development. Eight staff files reviewed (six RNs, two caregivers) reflected evidence of reference</p>

<p>Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>checking, signed employment contracts and job descriptions, completed orientation programmes and annual performance appraisals. The orientation programme provides new staff with relevant information for safe work practice. Orientation is specific to the individual's job role and responsibilities.</p> <p>Current registered nursing staff and external health professionals (general practitioners, physiotherapist, pharmacists, podiatrist) practising certificates were sighted.</p> <p>There is an implemented annual education and training plan that exceeds eight hours annually per staff member. Training is primarily online with competency assessments linked to training. A register for each training session and an individual staff member record of training was verified.</p> <p>Registered nurses are supported to maintain their professional competency. Twelve of the fourteen registered nurses have completed their interRAI training. Eleven caregivers have achieved their Careerforce level four, and twelve have achieved their Careerforce level three.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The human resources policy determines staffing levels and skill mixes for safe service delivery. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.</p> <p>The care manager and senior RN are rostered Monday to Friday and on call. There is a trained first aider on each shift. The activity staff also have first aid certificates.</p> <p>The service is on two floors and each floor is staffed separately.</p> <p>Ground level (2 rest home and 27 hospital): two RNs are rostered on the AM and PM shifts and one RN is rostered for the night shift. Three long shift (7-8 hour) and two short shift caregivers (to 1300) cover the AM shift, two long shift and one short shift caregivers (to 2100) cover the PM shift and two caregivers cover the night shift.</p> <p>First level (1 rest home and 48 hospital): two RNs are rostered on the AM and PM shifts and one RN is rostered for the night shift. Four long shift (7-8 hour) and four short shift caregivers (to 1300) cover the AM shift, three long shift and three short shift caregivers (to 2100) cover the PM shift and two caregivers cover the night shift.</p> <p>Residents and relatives stated there were adequate staff on duty. Staff stated they feel supported by the RNs. The GP stated staffing was adequate.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p>	<p>FA</p>	<p>The resident files were appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record.</p>

<p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>		<p>Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are held electronically using Leecare Solutions. They are protected from unauthorised access. Entries are computerised, dated and include the relevant caregiver or nurse including their designation. Individual resident files demonstrate service integration.</p>
<p>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.</p>	<p>FA</p>	<p>Residents are assessed prior to entry to the service by the need's assessment team, and the clinical manager reviews all referrals prior to admission to ensure the service is able to provide the level of care needed. An initial assessment was completed on admission in files sampled. The service has an information pack available for residents/families/whānau at entry and it includes associated information such as the Code, advocacy, informed consent, and the complaints procedure. All files reviewed included the admission agreement, which aligns with the age-related residential care services agreement contract, exclusions from the service are included in the admission agreement.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admission to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. Relatives interviewed, confirmed they were kept well informed about all matters pertaining to residents, especially if there is a change in the resident's condition.</p>
<p>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.</p>	<p>FA</p>	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Medicine management complies with current medication guidelines. Medication reconciliation of medication packs is completed by the RN and any errors fed back to the pharmacy. Registered nurses, and medication competent caregivers who administer medications, have been assessed for competency. Education around safe medication administration has been provided annually. The service uses an electronic medication system. Medications were stored safely in three secure medication rooms (two downstairs and one upstairs). The medication fridges and medication rooms are monitored weekly. All eye drops and creams in medication trolleys were dated on opening. One resident was self-medicating on the day of audit; resident assessments and consents had been completed according to the medication policy.</p> <p>Eighteen electronic medication charts from across the service were reviewed. All medication charts had photographs and allergies documented and had been reviewed at least three-monthly by the GP. The electronic medication charts included as needed medication, regular medications and</p>

		<p>nurse-initiated medications. Nurse-initiated medications were all charted correctly and included a three-monthly review by the GP.</p> <p>Medication records demonstrated that medications are administered as prescribed and the indication for use is documented for 'as required' medications. The effectiveness of 'as required' medications is entered into the electronic medication system and in the progress notes.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The food service is contracted to an external catering company who use the facility in a separate building kitchen to prepare and cook meals. Meals are transported in insulated boxes to each kitchenette for serving. The service has a kitchen manual. An eight-weekly seasonal menu is implemented. A dietitian has reviewed and approved the menu and there is a verified food control plan in place. All residents have a dietary requirements chart completed on admission.</p> <p>The cook receives a copy of each resident's dietary requirements that include likes/dislikes and the cook visits residents to seek feedback. Alternative food choices are offered and provided as needed. There is evidence of modified diets being provided (eg, diabetic menu) and further nutritional supplements.</p> <p>Residents and relatives interviewed confirmed likes/dislikes are accommodated and advised that the food service has improved over the last three months. Fridge and freezer temperatures are recorded daily.</p> <p>The kitchen was observed to be clean and well maintained. Chemicals are stored safely, and safety datasheets are available. Personal protective equipment is readily available, and staff were observed to be wearing hats, aprons and gloves. All kitchen staff have received appropriate food safety training.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The service records the reason for declining service entry to potential residents should this occur and communicates this decision to potential residents/family/whānau. Anyone declined entry is referred to the referring agency for appropriate placement and advice.</p>
<p>Standard 1.3.4: Assessment</p>	FA	<p>All eight long term resident files reviewed evidenced a care needs level assessment completed by the need's assessment and service coordination team (NASC) prior to admission, one ICP funded</p>

<p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>		<p>resident's file included assessment and direction for care by the DHB.</p> <p>Personal needs information was gathered during admission, which formed the basis of resident goals and objectives in files sampled (including the ICP resident file). Appropriate assessment tools were completed, and assessments were reviewed at least six monthly or when there was a change to a resident's health condition in files sampled. Assessments such as behavioural assessments were completed for identified behavioural issues in files sampled. The interRAI assessment tool was evident in all eight long term resident files sampled.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Low</p>	<p>Nine resident files were reviewed and included a range of issues including weight loss, a pressure injury, falls, a resident who was blind, a resident with behaviours that challenge, two residents with an indwelling catheter, a resident with a partner also in the care centre and an ICP funded resident. Resident files reviewed, and family interviews identified that family were involved in the care plan development and ongoing care needs of the resident. The initial care plan is developed from the initial assessment and identifies the areas of concern or risk. All resident files reviewed included an electronic care plan documented. Not all CAPs from the interRAI assessments and not all risks and care needs identified by staff, the GP, family and allied services were fully documented.</p> <p>Short-term care plans were utilised for acute health needs such as infections. Staff interviewed reported they found the plans easy to follow and that handovers informed them of resident care needs.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Moderate</p>	<p>RNs and caregivers report progress against the care plan at least daily. If external nursing or allied health advice is required the RNs will initiate a referral (eg, to the wound specialist nurse). If external medical advice is required, this will be actioned by the GP. Communication with family is documented in progress notes and family contact notes. Short-term care plans are available for use for changes in health status. The GP, residents and families spoke highly of the care provided.</p> <p>Continence products are available and resident files include a urinary continence assessment. Specialist continence advice is available as needed and this could be described by the registered nurse.</p> <p>Monthly weighs have been completed in all long-term files sampled. Referral to dietitian occurs as required, as confirmed in sampled files. Not all care was evidenced to be provided according to the care plan and not all monitoring was documented according to the care plan instruction.</p> <p>Wound assessment, wound management plans and monitoring were in place for all identified wounds. There were six pressure injuries at the time of audit, four were facility acquired. There</p>

		<p>were three stage one, one stage two, one stage three, and one unstageable. The service has a wound champion who was aware of the high level of pressure injuries and was able to show the process and plan to educate staff and improve skin care. The incidence of pressure injuries has increased slightly in the last six months but overall has decreased over the year from March 2020.</p> <p>Wounds have been reviewed in appropriate timeframes and specialised wound management advice through the district nursing service was evident in wounds reviewed. Dressing supplies are available, and the treatment room is stocked for use.</p> <p>Interviews with registered nurses (including the clinical manager) and caregivers demonstrated an understanding of the individualised needs of residents.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	CI	<p>Sarah Selwyn has implemented a programme over six days a week for the hospital and rest home as well as some evening sessions. The two qualified diversional therapists are responsible for developing the programme. Each resident has an individual life style support assessment (activities assessment) and life story on admission and from this information an individual activities plan is developed as part of the care plan by the registered nurses, with input from the activities staff. Residents are free to choose when and what activities they wish to participate in. An individual activities attendance register is maintained.</p> <p>The activity team have developed the activity programme and activity plan based around the principles of partnership, participation and protection. Through this process cultural needs are addressed well for all cultures. Individual resident needs are considered and provided for as much as possible. The DT explained that this holistic approach has improved the activities for residents as they are part of the planning and they are supported in the activities of their choice.</p> <p>The activity programme includes: cooking (the chutney group) who have also produced a recipe book with memories shared of cooking in the past, a poetry group, lots of exercise sessions for differing levels of ability, word games, bingo, sensory and relaxation lessons, entertainment and craft and community visits. There is a focus on promoting and improving activities for all residents and residents have input into the activities provided. Family interviews indicated they find the programme enjoyable and interesting. The service has exceeded the standard required for the provision of activities.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive</p>	FA	<p>The registered nurses evaluate all initial care plans within three weeks of admission. Comprehensive evaluations reviewed were completed six-monthly by a RN and changes to care documented in the care plan. A written care plan evaluation is completed. Short-term care plans are</p>

<p>and timely manner.</p>		<p>evaluated and resolved or added to the long-term care plan.</p> <p>The GP reviews the residents three-monthly or when requested, if issues arise or health status changes. The GP expressed satisfaction with the service and advised that nursing staff are prompt at informing of changes in the residents' condition and carry out instructions.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>The service facilitates access to other medical and non-medical services, (eg, diabetic services, wound nurse specialist services, physiotherapist and mental health services for older people). Referrals to specialists are made by the GP. Referral forms and documentation are maintained on resident files as sighted. Family/whānau interviewed, reported they are involved as appropriate when referral to another service happens. Referrals and options for care were discussed with the family, as evidenced in interviews and medical notes. The staff provided examples of where a resident's condition had changed, and the resident was reassessed.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>There are policies and procedures in place for the storage and use of chemicals. Safety data sheets are available for staff. There is a chemical spills kit readily accessible. There have been no incidents regarding chemical spillage or accidents. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances. There are policies and procedures in place for the management of waste. Three sluice rooms are available for the disposal of waste and hazardous substances.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building has two levels. The building has two levels, there are two lifts between floors, one is large enough for a stretcher and one smaller lift. The building holds a current warrant of fitness which is displayed. Fire drills occur six-monthly. There is a maintenance work notification book for staff to communicate with maintenance staff on issues and areas that require attention. A preventative maintenance schedule is in place for the service. Hot water temperatures are monitored and recorded monthly. Electrical equipment is tested and tagged. All hoists have been checked and serviced and medical equipment has been calibrated and checked. The facility vans are registered, and each has a current warrant of fitness.</p> <p>Residents were observed moving easily around the building with walking aids, wheelchairs and independently.</p> <p>There are outside courtyard areas with seating, tables and shaded areas that are easily accessible. All hazards have been identified in the hazard register.</p>

<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There is a combination of ensuite rooms and non ensuite rooms. There are communal toilets and bathrooms easily available to all bedrooms in all areas as well as communal areas. Handrails are appropriately placed in ensuite bathrooms and communal showers and toilets. Privacy is assured with the use of ensuites. Communal toilet/shower/bathing facilities have a system that indicates if it is engaged or vacant. Fixtures, fittings, floorings and wall coverings are in good condition and are made from materials which allow for ease of cleaning. Hot water temperatures are monitored monthly and are within safe range as per current guidelines and legislation.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Bedrooms in all the units are spacious and of an adequate size appropriate to the level of care provided. The rooms allow for the easy manoeuvre of hoists, lazy boy chairs and other equipment required to safely deliver care. Residents and their families are encouraged to personalise the bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Residents have access to lounges, dining rooms and other communal areas throughout the facility. Residents interviewed confirmed there are areas available to them if they want to sit quietly or entertain others or if they don't want to participate in activities offered. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely. All the corridors are wide with appropriately placed handrails. Residents interviewed stated that they are happy with the dining and lounge facilities.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Dedicated cleaning staff are rostered on to clean the facility. They 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 are satisfied with the standard of cleanliness in the facility.</p> <p>Dedicated laundry staff complete all laundry on site in an appropriately appointed laundry. Residents interviewed were satisfied with the laundry service.</p>

<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>There is at least one staff member on duty at all times with a first aid certificate including on outings. Emergency preparedness plans are accessible to staff and includes management of all potential emergency situations. The service has implemented policies and procedures for civil defence and other emergencies. The service has civil defence resources and supplies. There are sufficient first aid and dressing supplies available. The service has an approved fire evacuation scheme. Fire evacuation training and drills are conducted six-monthly.</p> <p>There are alternative cooking facilities and adequate water supplies for emergency use. Call bells are situated in all communal areas, toilets, bathrooms and personal bedrooms. Residents were sighted to have call bells within reach during the audit. Call bells are tested by maintenance every month. Visitor's sign-in/out at reception, including contractors.</p> <p>Appropriate security systems are in place.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>General living areas and all resident rooms are appropriately heated and ventilated. All rooms have external windows that open allowing plenty of natural light.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>The infection control coordinator (IC), is a senior RN and has a signed job description on file. Infection control is part of the registered nurse meetings and is included as a part of the quality meetings. The infection control programme has been reviewed annually by the central office. Spot audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. Visitors are asked not to visit if they have been unwell. There are hand sanitisers throughout the facility and adequate supplies of personal protective equipment. There have been no outbreaks. The IC is aware of situations where there is requirement to notify authorities.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources</p>	<p>FA</p>	<p>A registered nurse is the designated infection control (IC) coordinator. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC coordinator and IC team (comprising all staff) have good external support from the local laboratory infection control team, the infection control team and head office and IC nurse</p>

<p>to implement the infection control programme and meet the needs of the organisation.</p>		<p>specialist at the DHB. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</p> <p>Sarah Selwyn as part of the Selwyn group have been proactive around the management of Covid-19 and the service has operated at one level higher than the alert levels to protect the vulnerable residents in their care. There are documented Covid-19 management and prevention guidelines documented for staff. The service has implemented an enhanced cleaning programme. The Selwyn group have set up a staff support programme with an 0800 number for staff. Additional training has been provided for all staff through Selwyn learn and during handovers. A process for cohort nursing can be implemented as needed. Staff were well formed around PPE and isolation processes. All visitors are screened.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>There are Selwyn 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 have been reviewed and updated annually.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The infection control 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. 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.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed</p>	<p>FA</p>	<p>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. Short-term care plans are used. Surveillance of all infections is</p>

<p>objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at RN and quality meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the village manager and care manager. There have been no outbreaks since the previous audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Restraint practices are only used where it is clinically indicated, and other de-escalation strategies have been ineffective. Restraint minimisation policies and procedures are comprehensive and include definitions, processes and use of restraints and enablers. The restraint coordinator is a registered nurse.</p> <p>There were two (hospital) residents using enablers and eight (hospital) residents with restraints (bed rails [6] and chair briefs [2]).</p> <p>The file of one resident using an enabler (bedrails) was reviewed. Evidence of an enabler assessment and written consent by the resident was sighted. The resident's care plan reflected the use of an enabler and the enabler is monitored two-hourly. Enablers are reviewed every month.</p> <p>Staff training is in place around restraint minimisation and enablers, falls prevention and management of challenging behaviours.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>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.</p>	<p>FA</p>	<p>The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities of 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.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in</p>	<p>FA</p>	<p>A restraint assessment tool is completed for residents requiring an approved restraint for safety. Assessments are undertaken by the restraint coordinator in partnership with the RNs, GP, resident and their family/whānau. Restraint assessments are based on information in the care plan, resident/family discussions and observations.</p> <p>Ongoing consultation with the resident and family/whānau are evident. Two hospital level residents'</p>

relation to use of restraint.		files where restraint was in use (chair briefs) were selected for review. The completed assessment and care plan for one of the residents using a chair brief indicated a bedrail was in use (which had been discontinued) and failed to indicate that a chair brief was in use as a restraint (link 1.3.5.1). The second resident file reviewed where restraint (chair brief) was in use covered all aspects of the criterion (a) – (h).
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	<p>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.</p> <p>Monthly 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 is documented on a specific restraint monitoring form, evidenced in two resident files where restraint (chair briefs) were being used but monitoring timeframes for both residents did not indicate that the restraint was checked/released two-hourly (at a minimum) (link 1.3.6.1).</p> <p>Risks associated with the use of chair-briefs for one resident was not documented either in the resident's restraint assessment or in the resident's care plan (link 1.3.5.1).</p> <p>A restraint register is in place providing an auditable record of restraint use and is completed for all residents requiring restraints and enablers.</p>
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	PA Low	<p>The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations are scheduled to be conducted six-monthly (at a minimum) although the two residents' files with restraint in use did not reflect regular evaluations as per this schedule.</p> <p>Restraint use is discussed at both registered nurse and staff meetings.</p>
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 organisation-wide restraint coordinators meetings, monthly registered nurse meetings and monthly staff meetings. Restraint education and training is completed annually through the Selwyn learning programme. Internal restraint audits are completed monthly.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	PA Low	All resident files reviewed included an electronic care plan documented. Not all CAPs from the interRAI assessments and not all risks and care needs identified by staff, the GP, family and allied services were fully documented.	<p>Interventions for a rest home level resident who was blind were not well documented to assist her safe mobilisation and communication.</p> <p>(i). One hospital level resident with behaviours that challenge had interventions describing the behaviour and environmental ways to assist calmness, but not interventions for when the resident became agitated.</p> <p>(ii). One resident had an</p>	<p>(i). Ensure that nursing interventions are documented in the resident care plan.</p> <p>(ii). Ensure that the correct restraint information is</p>

			incorrect restraint recorded in the care plan and did not include the risks associated with the (incorrect) restraint.	documented in the care plan and the risks associated with its use. 90 days
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Moderate</p>	<p>There were care plans in place for all nine resident files reviewed. Monitoring needed, and timeframes were documented on care plans and also on monitoring charts. Staff reported the importance of monitoring; however, this was not always documented as having occurred. Families and resident praised the care delivered but this was not evidenced as always being according to the care plan.</p>	<p>(i). Neurological observations were not consistently documented for three unwitnessed falls.</p> <p>(ii). Restraint monitoring was not documented according to time frames for two of three files reviewed for residents with restraint.</p> <p>(iii). One resident's care plan prescribed an agreed routine during the day to assist with management of behaviours that challenge; this included sitting in a specific chair in the morning, a rest in bed after lunch and regular monitoring/repositioning. This routine was not complied with. The resident was observed sitting in his room in an incorrect chair, the floor was wet, there was no sensor mat in place and no monitoring documented as per care plan (this was rectified by the RN at the time</p>	<p>(i)-(ii). Ensure that all monitoring is documented as per timeframes.</p> <p>(iii). Ensure all carer and support is provided as per the care plan.</p> <p>90 days</p>

			of audit).	
<p>Criterion 2.2.4.1</p> <p>Each episode of restraint is evaluated in collaboration with the consumer and shall consider:</p> <p>(a) Future options to avoid the use of restraint;</p> <p>(b) Whether the consumer's service delivery plan (or crisis plan) was followed;</p> <p>(c) Any review or modification required to the consumer's service delivery plan (or crisis plan);</p> <p>(d) Whether the desired outcome was achieved;</p> <p>(e) Whether the restraint was the least restrictive option to achieve the desired outcome;</p> <p>(f) The duration of the restraint episode and whether this was for the least amount of time required;</p> <p>(g) The impact the restraint had on the consumer;</p> <p>(h) Whether appropriate advocacy/support was provided or facilitated;</p> <p>(i) Whether the observations and monitoring were adequate and maintained the safety of the consumer;</p> <p>(j) Whether the service's policies and procedures were followed;</p> <p>(k) Any suggested changes or additions required to the restraint education for service providers.</p>	PA Low	Restraint evaluations did not reflect evidence of regular reviews.	An evaluation process is in place for resident's using restraint. This is completed electronically. The restraint coordinator was unaware of how to correctly use this electronic system (Leecare) to document evaluations, and therefore evaluations did not reflect regular reviews.	<p>Ensure the electronic system for documenting restraint evaluations are done correctly to indicate that they are reviewed as per policy (six monthly at a minimum).</p> <p>90 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	CI	A list of quality initiatives that have been implemented since the previous audit have reflected attainment beyond what is expected.	The achievement of the rating that the service provides an environment that encourages quality initiatives is beyond the expected full attainment. The service has conducted a number of quality improvement projects where a review process has occurred, including analysis and reporting of findings has occurred. There is evidence of actions taken based on findings that has made improvements to service provision. The projects include reviewing if the improvements have had positive impacts on resident safety or resident satisfaction. Examples provided include the implementation of a daily huddle for all shifts that has resulted in a more cohesive team, a sharing of ideas on what is working well, provided increased support for new registered nurses and has improved communication within the care team on each shift; implementing a stop and watch tool for residents who are deteriorating; implementing measures to more effectively acknowledge a resident's end of life journey through timely and anticipatory medication referrals to the GP and the timely start of residents on syringe drivers to ensure comfort, collaboration with external specialists, timely family meetings, implementing a guard of honour for deceased residents; and the implementation of a predictive tool to identify the pressure injury risk of residents and their equipment requirements based on interRAI and clinical assessments to ensure that adequate pressure relieving equipment is always available

<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	<p>CI</p>	<p>Sarah Selwyn has a committed team of management and DTs who are committed to improving the outcomes for residents through care and also through activities. Regular discussion, encouraging new ideas and the involvement of residents in the development of the activities has demonstrated improvements for residents over time.</p>	<p>The action plan to improve activities included increasing the range of activities. The activities chosen for the updated activity plans were implemented following resident feedback and consultation, staff brainstorming ideas and weekly meetings between the DTs and the manager. Activities are based around the principles of partnership, participation and protection. Family, resident and staff involvement were described by staff and residents around activities to be considered.</p> <p>Initiatives have included exercise programmes, visits from school children, community picnics and outings, and a beauty therapist visits. Evening activities have been commenced so that family can attend. Residents are invited to suggest ideas at resident meetings and the service accommodates wishes as much as possible.</p> <p>As a result of this integrated and participative approach, the interRAI depression rating score for residents at Sarah Selwyn has remained lower than seven of the nine Selwyn homes for the last four quarters year to date (only one service had lower scores). The service was also noted to be proactive with using data such as interRAI to review its programmes (including activities) with a view to improving.</p>
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End of the report.