Selwyn Care Limited - Kerridge House

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:	Kerridge House
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 29 March 2021 End date: 30 April 2021

Proposed changes to current services (if any): The service requests removing hospital services-geriatric services from their current certification.

Total beds occupied across all premises included in the audit on the first day of the audit: 59

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Selwyn Kerridge House is owned and operated by the Selwyn Foundation. The service provides care for up to 60 residents requiring rest home level care. On the day of the audit there were 59 residents. All residents were under the Age-Related Residential Care contract.

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 has been in the role since September 2018, has a master's degree in medical/surgical nursing and has worked in the aged care industry since 2014. Residents, relatives and the GP interviewed spoke positively about the service provided.

The service has exceeded the standard around: activities, quality improvements and infection control.

This audit has identified one area for improvement 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.

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 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 low risk.

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 seven days a week with RN oversight available (two afternoon shifts and nights) at another aged care facility located in the Selwyn Village. 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.		All standards applicable to this service fully attained with some standards exceeded.

Residents are assessed prior to entry to the service. A baseline assessment is completed upon admission and an interRAI assessment within three weeks. Long-term care plans are developed by the service's registered nurses, who also have the responsibility for maintaining and reviewing the care plans.

InterRAI assessment tools and monitoring forms are used to assess the level of risk and ongoing support required for residents. 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. 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.

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 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.		Standards applicable to this service fully attained.

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

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.		All standards applicable to this service fully attained with some standards exceeded.

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. The programme 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 as part of 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. There have been no outbreaks since the previous audit.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	2	42	0	1	0	0	0
Criteria	3	89	0	1	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

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	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 thirteen staff (three caregivers, three registered nurses (RNs), one kitchen manager, one kitchenhand, one maintenance, one housekeeper, two diversional therapists, one physiotherapist) reflected their understanding of the Code with examples provided of how it is applicable to their job role and responsibilities. Six rest home residents and three rest home relatives interviewed confirmed that staff respect their 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	FA	Informed consent processes are discussed with residents and families on admission. The resident or their EPOA signs written consents. Advance 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 clinical 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.

informed consent.		Eight of eight resident files sampled have a signed admission agreement and consents.
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 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.
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 with examples provided (eg, walks to the local café). 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 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). There is a complaint register available. Seven complaints were registered in 2020 and no complaints have been lodged in 2021 (year-to-date). Four complaints were reviewed in detail. All four complaints reflected evidence of acknowledgement, a comprehensive investigation and communication with the complainant within the timeframes determined by HDC. Two complaints reviewed resulted in a corrective action plan (quality improvement plan [QIP]). The complaints process is linked to quality and risk management processes.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	There is an information pack given to prospective residents and families that includes information about the Code and their right to make a complaint. There is the opportunity to discuss aspects of 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.
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. 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 can describe definitions around abuse and neglect. Residents and relatives interviewed confirmed that staff treat residents with respect. 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 are considered. This was also evidenced in the residents' files reviewed. Caregivers interviewed 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 and provides recognition of Māori values and beliefs. A local kaumātua is available as required. Māori holidays are celebrated (eg, Waitangi Day). Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. 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.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	An initial care planning meeting is carried out 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 are invited to attend. Discussions with relatives confirmed that residents' values and beliefs are considered. Residents interviewed confirmed that staff take into account their values and beliefs.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion,	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.

harassment, sexual, financial, or other exploitation.		
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. 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 staff on each shift. Residents and family advised that the RNs and caregivers are caring and competent. A general practitioner (GP) is available twice per week. The building has recently been refurbished with new carpet, painting, new non-slip flooring installed at the entrance and replacement of the dining chairs and tables in the main dining room.
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 ten incident/accident reports reviewed meet this requirement. Families interviewed confirmed they are notified following a change of health status and/or accident/incident of their family member. There is an interpreter policy in place and contact details of interpreters are available. At the time of the audit, all residents spoke fluent English.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Selwyn Kerridge House is owned and operated by the Selwyn Foundation. The service provides care for up to 60 residents requiring rest home level care. On the day of the audit there were 59 residents. All residents were under the Age-Related Residential Care contract (ARRC). This service is also certified for hospital level care; however they do not provide this level of care. The service has requested the hospital level care be removed from their current certificate. This aged care facility, located in the Selwyn Village in Pt Chevalier, Auckland, is managed by a care manager/registered nurse and is overseen by a village manager who has been in the position since April 2017. The care manager has been in the role since September 2018, has a master's degree in medical/surgical nursing and has worked in the aged care industry since 2014. The Selwyn Foundation has an overarching five-year strategic plan (2018 to 2022). The strategic plan includes a mission statement, and vision and values of the organisation. The service has a business

		plan, 2020 – 2021 which is linked to the strategic plan and reviewed monthly. The care manager has completed at least eight hours of professional development relating 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 clinical and quality manager/RN covers during the temporary absence of the 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 principles.	FA	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. 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. The services 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. The quality management programme is overseen by the clinical quality manager. 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 tears). This data is benchmarked against other Selwyn aged care facilities and externally with other large aged care providers. Results are utilised for service improvements. Internal audits are conducted as per the internal audit schedule. Staff are kept informed of quality results via meetings and during handovers. Quality improvement plans (QIPs) are developed where service shortfalls are identified (eg, incidents/accidents, internal audit results, key performance indicator data, complaints received, critical events). QIPs, internal audits and meeting minutes reflect the actions being implemented.

		Health and safety policies are implemented. A caregiver is the designated health and safety representative and has completed stage one health and safety training. 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 training during their orientation. Staff continue with regular health and safety training. Health and safety is a regular agenda item in the staff meetings. Falls prevention strategies are in place including (but not limited to): sensor mats, increased monitoring for those residents at high risk of falling, and the identification and meeting of individual resident needs. A physiotherapist is available and assesses all new residents and provides input for residents who have fallen. The rate of falls has steadily dropped in 2020 – 2021 (year-to-date), and is below the Selwyn threshold, and has resulted in a rating of continuous improvement.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	PA Low	There is an incident/accident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise and debriefing. Individual incident/accident reports are completed for each incident/accident with immediate action noted and any follow-up action required. A review of ten incident/accident forms (skin tears; witnessed and unwitnessed falls) identified that the incident/accident forms are fully completed and include follow-up by a registered nurse. Missing was evidence of neurological observations being completed in a consistent manner for two residents who sustained direct injuries to their head. 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.
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	Human resources policies include recruitment, selection, orientation and staff training and development. Six staff files reviewed (two RNs, three caregivers, one diversional therapist) reflected evidence of reference checking, signed employment contracts and job descriptions, completed orientation programmes and performance appraisals that begin during the new staff's orientation at four weeks, eight weeks and twelve weeks. The orientation programme provides new staff with relevant information for safe work practice. Orientation is specific to the individual's job role and responsibilities. Current registered nursing staff and external health professionals (general practitioners, physiotherapist, pharmacists, podiatrist) practising certificates were sighted.

		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. Registered nurses are supported to maintain their professional competency. All three registered nurses have completed their interRAI training. All twenty caregivers have achieved either their Careerforce level two, three or four qualification.
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. Rosters implement the staffing rationale. The care manager (RN) works full-time Monday to Friday and is available on call 24/7. Barnyard wing (27 residents): a care supervisor (senior caregiver) is rostered in addition to one long shift and one short shift (to 1300) caregiver. The PM shift is staffed the same as the AM shift with the short shift staff working 1600 – 2100. One caregiver is rostered for this wing during the night shift. Alan Catley wing (32 residents): an RN is based in this wing (with oversight to the entire facility) seven day shifts a week. Two long and one short shift caregiver (to 1300) are rostered for the AM shift. The PM shift is staffed with an RN five days a week (Wednesday – Sunday). One caregiver is rostered for the night shift. RN oversight is provided for the night shift and the PM shift (Monday and Tuesday) by an RN located in the same village (Selwyn Sarah Selwyn) where a minimum of two RNs are rostered 24/7. Two RNs are available one day a week for assistance with paperwork (eg, interRAI) and GP rounds. Staff are visible and attend to call bells in a timely manner as confirmed by all resident and relatives interviewed. Staff interviewed stated that overall, the staffing levels are satisfactory and that the care manager provides good support. Residents and relatives interviewed reported there are sufficient staff numbers. Selwyn Foundation has its own bureau of nursing staff to cover sick leave and annual leave. The care manager is available on call if required. There is low staff turnover as reported by the care manager.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely	FA	The resident files were appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are held electronically using Leecare Solutions. They are protected from unauthorised access. Entries are computerised, dated and include the relevant caregiver or nurse

identifiable, accurately recorded, current, confidential, and accessible when required.		including their 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	Residents are assessed prior to entry to the service by the need's assessment team, and the care 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.
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 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.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	There are 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 two secure medication rooms. 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. Sixteen 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 nurse-initiated medications. Nurse initiated medications were all charted correctly and included a three-monthly review by the GP. 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.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	The 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 insulted 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. 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. Residents and relatives interviewed confirmed likes/dislikes are accommodated and praised the meals. Fridge and freezer temperatures are recorded daily. 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.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	The service records the reason for declining service entry to potential residents should this occur and communicates this decision to potential residents/family/whānau. Anyone declined entry is referred to the referring agency for appropriate placement and advice.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	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 resident’s file included assessment and direction for care by the DHB. Personal needs information was gathered during admission, which formed the basis of resident goals and objectives in files sampled. 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.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Eight resident files were reviewed and included a range of issues including a resident with a chronic wound, two residents with high falls, a resident with weight loss, a resident on warfarin, two residents with behaviours that challenge and a new 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. 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.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	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. 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. Monthly weighs have been completed in all long-term files sampled. Referral to dietitian occurs as required, as confirmed in sampled files. Wound assessment, wound management plans and monitoring were in place for all identified wounds. There were nine wounds documented at the time of audit, there were no pressure injuries. Wounds have been reviewed in appropriate timeframes. The service has an implemented process of referring any wound that has not healed within four weeks to the nurse specialist 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. Interviews with registered nurses (including the care manager) and caregivers demonstrated an understanding of the individualised needs of residents.

Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	CI	Selwyn Kerridge House has implemented a programme over seven days a week. The two qualified diversional therapists are responsible for developing the programme. Each resident has an individual lifestyle 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. Families and residents interviewed praised the activity programme. The activity programme includes: exercises, bus trips, resident lead quizzes, Mr Whippy, games, a women's group, a men's group, Zumba, baby buddies, yoga, themed days cultural and spiritual activities. 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. They reviewed the activities programme in 2019 with a view to improving the resident experience, and as a result the activity programme was improved. The service has exceeded the standard required for the provision of activities.
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. Comprehensive evaluations reviewed were completed six-monthly by a RN and changes to care documented in the care plan. Short-term care plans are evaluated and resolved or added to the long-term care plan. 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.
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, (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.

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	The service has documented policies and procedures for the safe and appropriate storage and disposal of waste and hazardous substances. Waste is appropriately managed. Chemicals are secured in designated locked cupboards. Chemicals are labelled, and safety data sheets are available throughout the facility and accessible to staff. Safe chemical handling training has been provided. Personal protective equipment/clothing is available in all high-risk areas. Staff were observed wearing protective equipment and demonstrated knowledge of handling chemicals.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building holds a current warrant of fitness, which expires 28 May 2021 (the process has commenced for a new warrant of fitness). The building is single storey and divided into two wings. Twenty-four beds in the hospital (Banyard wing) are dual purpose. The Selwyn Foundation employs a full-time property manager and three maintenance officers. There are proactive and reactive maintenance management plans in place. Contracted providers test equipment. Electrical testing of non-hardwired equipment and medical equipment requiring servicing and calibration is conducted annually. There are hazard management systems in place to ensure the physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the residents and any visitors or contractors to the facility. Residents have adequate internal space to meet their needs. External areas are safe and well maintained. The facility has a van available for transportation of residents. Those transporting residents are designated drivers.
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 adequate toilets and showers for residents. Separate visitor and staff toilet facilities are available. Water temperatures are monitored, and temperatures are maintained at or below 45 degrees Celsius. Records sighted evidenced that corrective actions are implemented and evaluated when temperatures are above the target range. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with	FA	Resident rooms are spacious. Walking frames, wheelchairs and hoists can be manoeuvred around the bed within the rooms, if required. Residents requiring transportation between rooms or services can be moved from their room either by trolley or by wheelchair.

adequate personal space/bed areas appropriate to the consumer group and setting.		
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 lounge/dining area. There are several other lounge areas in each wing which can be used for activities or for residents to access when they want some quiet/private time with family or friends. There are garden areas and courtyards which contain seating and shade. There are raised garden planters and vegetable gardens which are easy for residents to access for gardening.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	All laundry is completed at the centralised laundry located on The Selwyn Foundation site. Laundry is picked up and delivered daily. There is a laundry on the premises which provides a clean area for delivery and folding of resident's personal laundry. There is a separate storage area for pickup of dirty laundry. Residents and relatives expressed satisfaction with cleaning and laundry services. The service has secure cupboards for the storage of cleaning chemicals. Chemicals are labelled. Material safety data sheets are displayed. Cleaning processes are monitored for effectiveness and compliance with the service policies and procedures. Cleaning staff have completed chemical safety training.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	There is an emergency response and civil defence plan to guide staff in managing emergencies and disasters. Emergency response and first aid is included in the mandatory in-service programme. There is a first aid trained staff member on every shift. Staff records sampled documented current training regarding fire, emergency and security education and six-monthly fire evacuation training. Information in relation to emergency and security situations is readily available/displayed for service providers and residents. Two civil defence kits include (but not limited to): torches, extra food supplies, blankets, batteries and cell phones. There is a gas barbeque, should the mains gas supply fail. The service has adequate stored water including water tanks for an emergency. An appropriate call bell system is easily used by the resident or staff to summon assistance if required. Call bells are within easy reach and are available in resident areas (eg, bedrooms, ensuites, the lounge and dining room). CCTV cameras are installed to monitor main corridors and exits; these do not impinge on resident privacy. A security company monitors the facility overnight. External doors are locked overnight during the hours of darkness.

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	The facility is light and airy and able to be ventilated by opening external windows and doors. There is electric heating with heat pumps and air conditioning installed in public areas. Internal temperatures are monitored and regulated by the maintenance team.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	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.
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 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 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. Selwyn Kerridge House 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.
Standard 3.3: Policies and	FA	There are Selwyn infection control policies and procedures appropriate to the size and complexity of the

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.		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.
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. 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.	CI	Infection surveillance is an integral part of the infection control programme and is described in The Selwyn Foundation infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow-up, review and resolution. Acute care needs support care plans are used. Surveillance of all infections is entered on to a monthly infection summary. This data is monitored and evaluated monthly and annually and provided to Selwyn head office for benchmarking. Infections are part of the key performance indicators. Outcomes and actions are discussed at quality/staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible. There have been no outbreaks since the previous audit. The service has exceeded the standard around the use of surveillance activities to reduce the incidence of infection.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use	FA	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

of restraint is actively minimised.		nurse. There were no residents using either a restraint or an enabler. Staff training is in place around restraint minimisation and enablers, falls prevention and management of challenging behaviours.

Specific results for criterion where corrective actions are required

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

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

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

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 Low	The frequency of neurological observations, determined by the registered nurses, does not follow any consistent pattern and are irregular for those residents who have fallen and potentially sustained an injury to the head.	As per policy, the frequency of completing neurological observations is determined by the RN. On review of two residents who had an unwitnessed fall with a suspected injury to the head, neurological observations were completed only twice (two-hourly interval) for one resident, and only three times for another resident (three hourly and then 24 hours later). There was no evidence documented to suggest that the resident was stable before neurological observations were discontinued. On further review, unwitnessed falls in general did not reflect neurological observations being routinely recorded and then discontinued once the resident was determined to be stable by an RN.	Ensure the risk of a neurological event following an unwitnessed fall is assessed through the routine and regular recording of neurological observations until the RN has documented in the progress notes that the resident is stable and neurological observations can be discontinued. 90 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.

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	The rate of falls has reduced over the past twelve months and remains below the Selwyn benchmark.	Data collected and collated are used to identify areas that require improvement. Clinical indicator data has individual reference ranges for acceptable limits. Residents falls are monitored monthly with strategies implemented to reduce the number of falls including: highlighting residents at risk; providing falls prevention training for staff; ensuring adequate supervision of residents; and encouraging resident participation in the activities programme; physiotherapy assessments for residents at risk; routine checks of all residents specific to each resident’s needs (intentional rounding); the use of sensor mats; and increased staff awareness of residents who are at risk of falling. Caregivers and RNs interviewed were knowledgeable regarding preventing falls and identifying those residents who are at risk. The falls prevention programme is reviewed monthly and is regularly discussed at the monthly staff meetings and during shift handovers. Falls have been no higher than 5.85/1000 bed nights (March 2020 – August 2020) and have continued to drop (September 2020 – March 2021) to 3.55 falls per 1000 bed nights.

Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	CI	Selwyn Kerridge 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.	An action plan was developed in 2019 to improve the activities for residents. The action plan to improve activities included increasing the range of activities and linking the programme to the Selwyn engagement in life philosophy. The activities chosen for the updated activity plans were implemented following resident feedback and consultation. The DTs attended additional workshops and conferences as part of an upskilling process. Regular meetings with DT and management were documented to keep the improvement process on track. Residents were invited to suggest ideas at resident meetings and the service accommodates wishes as much as possible, increased community involvement was implemented as well as opening up the Selwyn gym to the residents. As a result of this integrated and participative approach, the interRAI depression rating score for residents at Selwyn Kerridge has remained lower than the national average. The service was also noted to be proactive with using data such as interRAI to review programmes (including activities) with a view to improving.
Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel	CI	When an infection occurs, an infection control report is completed and provided to the infection control coordinator. An acute care needs support care plan is also completed. The infection control coordinator keeps a monthly summary log of all infections and all are logged into the online database for benchmarking. Benchmarking results are provided to staff. A monthly report is provided to the group residential care manager. This includes actions taken, trends identified, proposals and actions indicated to reduce negative trends and analysis of the effectiveness of corrective actions. Overall infections including wound infections and urinary tract	In early 2020 the infection control coordinator identified that overall infections were above the Selwyn benchmark. All infections are comprehensively analysed for trends. Actions to reduce negative trends were identified and included staff and resident education, analysis of ideal products to be used, a wound care champion and increased fluid rounds in hot weather. The actions were identified, discussed at staff/quality meetings and implemented as needed. A new monthly reporting form has been developed and these have been comprehensively completed. Monthly reporting was documented and discussed with staff. As a result of this detailed analysis and addressing of trends, Selwyn Kerridge House has reduced overall infections including UTIs and wound infections and are below the Selwyn benchmark.

and management in a timely manner.		infections have reduced since April 2020.	

End of the report.