Metlifecare Limited - Selwyn Park

Introduction

This report records the results of a Provisional 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 The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

Legal entity:	Metlifecare Limited
Premises audited:	Selwyn Park
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 29 November 2021 End date: 30 November 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: 85

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.

General overview of the audit

This provisional audit was undertaken to establish the prospective provider's preparedness to deliver residential aged care services and the current owner's level of conformity with the Health and Disability Services Standards and their agreements with the DHB. Selwyn Park Village provides rest home, dementia and hospital level care for up to 88 residents. The service is currently operated by the Selwyn Foundation and managed by a village manager supported by a care manager. Residents, relatives and the GP interviewed spoke positively about the service provided.

Metlifecare Limited - the prospective provider, has a sale and purchase agreement with Selwyn Care Limited to purchase Selwyn Park Village in Whangarei. Takeover is anticipated to occur in late February 2022 subsequent to obtaining approval from three regulatory bodies; the Ministry of Health (MOH), the Retirement Village Statutory Supervisor and the Overseas Investment Office.

Metlifecare is a New Zealand company established in 1984 which owns and operates a large portfolio of retirement villages and care homes in the North Island. The company is experienced in delivering aged care services through its ownership of 11 care homes and is purchasing six care facilities from Selwyn Care. Interview with the clinical nurse director provided evidence of

knowledge and understanding of the aged care sector and their preparedness to own and operate these additional facilities. Outcomes from the Metlifecare interview, review of the transition plans and the site visits conducted prior to sale and other due diligence activities, did not identify any areas of concern that potentially impacted on each facilities ability to meet HDSS requirements, or other legislative or regulatory compliance matters.

This audit process included a pre audit review of the prospective provider's policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, the current regional and on-site management and staff.

There have been no significant changes to the services provided or the facility since the previous certification audit in October 2020.The corrective action required from that audit was confirmed as rectified.

This audit has identified two areas for improvement around out of hours medication supplies and appropriate transport for community activities.

Consumer rights

The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents of Selwyn Park. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

Services are provided in a manner that respects the choices, personal privacy, independence, individual needs, and dignity of residents. Staff were observed interacting with residents in a respectful manner.

Care for residents who identify as Māori is guided by a comprehensive Māori health plan and related policies.

There was no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

Open communication between staff, residents and their families/whanau is promoted, and confirmed to be effective. There is access to formal interpreting services if required.

The service has linkages with a range of specialist health care providers, which contributes to ensuring services provided to residents are of an appropriate standard.

A complaints register is maintained with complaints resolved effectively, following organisational policy and procedures.

Organisational management

The current business and quality and risk management plans included the goals, values, priorities and direction of the organisation. Monitoring of the services provided to the governing body was regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people. Up to date, legible and relevant residents' records are maintained in using electronic files.

Continuum of service delivery

Selwyn Park works closely with the local Needs Assessment and Service Co-ordination Service, to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, relevant information is provided to the potential resident/family/whanau to facilitate the admission.

Residents' needs are assessed by the multidisciplinary team on admission within the required timeframes. Shift handovers, staff stability, and communication sheets guide continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Acute care plans are developed to manage any new problems that arise. All residents' files reviewed demonstrated that needs, goals, and outcomes are identified and reviewed on a regular basis. Residents and families/whānau interviewed reported being well informed and involved in care planning and evaluation. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme is overseen by a diversional therapist and provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings.

Medicines are managed using an electronic system. Medications are administered by registered nurses and care staff, all of whom have been assessed as competent to do so.

The contracted food service meets the nutritional needs of the residents with special needs catered for. Policies guide food service delivery supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents verified overall satisfaction with meals.

Safe and appropriate environment

The facility meets the needs of residents and was clean and well maintained. There was a current building warrant of fitness. Electrical equipment has been tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are managed safely. Staff have access to protective equipment and clothing and were observed using this. Chemicals are safely stored.

Electrical equipment is tested as required. External areas are accessible, safe and provide shade and seating for residents. All areas of the home are well maintained and cleaned to a high standard. Laundry is currently managed onsite.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised.

Residents reported a timely staff response to call bells. Security is maintained.

Restraint minimisation and safe practice

The organisation has implemented policies and procedures that support the minimisation of restraint. There were seven restraints in use and one resident using an enabler on the days of audit. All processes related to these had been completed. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes. All engage in ongoing training about prevention of restraint.

Infection prevention and control

The infection prevention and control programme, led by an experienced and appropriately trained infection control coordinator, aims to prevent, and manage infections. Specialist infection prevention and control advice is accessed from the district health board. The programme is reviewed annually.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken, analysed, trended, benchmarked and results reported through all levels of the organisation. Follow-up action is taken as and when required.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	48	0	2	0	0	0
Criteria	0	99	0	2	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	Selwyn Park has policies, procedures, and processes in place to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation's standard consent form including for photographs, outings, invasive procedures, and collection of health information. Advance care planning, establishing, and documenting enduring power of attorney (EPOAs) requirements and processes for residents unable

		to consent is defined and documented where relevant in the resident's file. Staff demonstrated their understanding by being able to explain situations when this may occur. The files of residents reviewed in the secure unit, had EPOAs in place that had been activated. Staff were observed to gain consent for day-to-day care on an ongoing basis.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters related to the Advocacy Service were also displayed in the facility, and additional brochures were available at reception. Family/whanau members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. Staff were aware of how to access the Advocacy Service.
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 are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. The facility has unrestricted visiting hours (when Covid alert levels do not require restrictions) and encourages visits from residents' families and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints/concerns policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. The complaints register reviewed showed that seven complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented and usually completed within agreed timeframes. Action plans showed any required follow up and

		improvements have been made where possible. The care manager is responsible for clinical complaints, the village manager for all others which are followed up in a timely way. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit, however two have been copied to the DHB. These have been fully investigated and all except one have now been closed off. The open complaint is currently being reviewed and responded to by the organisational operations manager.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Seven residents and their family/whanau (19) interviewed report being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussion with staff. The Code is displayed in common areas together with information on advocacy services, how to make a complaint and feedback forms. The prospective provider is aware and understands the consumer rights obligations that must be adhered to.
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	Residents and families/whanau confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality, and choices. Staff understood the need to maintain privacy and were observed doing so throughout the audit, when attending to personal cares, ensuring resident information is held securely and privately, when exchanging verbal information and during discussions with families/whanau. All residents have a private room. Surveillance cameras operate throughout communal areas at Selwyn Park. Notifications of surveillance cameras operating are displayed throughout the facility. Residents are encouraged to maintain their independence by participating (when Covid-19 limitations are not imposed) in community activities, regular outings to the local shops or areas of interest and participation in clubs of their choosing. Each plan included

		documentation related to the resident's abilities, and strategies to maximise independence. Records reviewed confirmed that each resident's individual cultural, religious, and social needs, values and beliefs had been identified, documented, and incorporated into their care plan. Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed by staff and training.
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	There are three residents and three staff members in Selwyn Park at the time of audit who identify as Māori. Interviews verified staff can support residents who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day-to-day practice, as is the importance of whānau to Māori residents. There is a current Māori health plan developed with input from cultural advisers. Selwyn's Park philosophy of care is displayed in English and te reo Māori on residents' notice boards.
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	Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences required interventions and special needs were included in all care plans reviewed, for example, food likes and dislikes and attention to preferences around activities of daily living. A resident satisfaction questionnaire includes evaluation of how well residents' cultural needs are met, and this supported those individual needs are being met.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to

		professional boundaries and expected behaviours. All registered nurses (RN's) have records of completion of the required training on professional boundaries. Staff are provided with a Code of Conduct as part of their individual employment contract. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, the hospice/palliative care team, wound care specialist, infection control nurse specialist, community dieticians, psychiatric services for older persons, access to external infection control advice from an external advisory company, and education of staff. The general practitioner (GP) at Selwyn Park is no longer practising so was unable to be interviewed at this audit, and unable to comment on the services level of practice. Staff reported they receive management support for external education and access their own professional networks. Other examples of good practice observed during the audit included a commitment to ongoing improvement in the care provided. Any deficits identified are immediately addressed in the comprehensive quality and risk programme (refer 1.2.3). There is a mandatory education programme that operates, with a full-time educator and assessor employed to manage training at Selwyn Park. Three RNs are currently being supported with post graduate training that includes clinical assessment skills, and living with chronic conditions papers. Two other RNs have completed post graduate papers in dementia, palliative care and clinical assessment, with the organisation's support.
Standard 1.1.9: Communication	FA	Residents and family/whanau members stated they were kept well informed about any changes to their own or their relative's status, were

Service providers communicate effectively with consumers and provide an environment conducive to effective communication.		advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. There was also evidence of resident/family/whanau input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. Interpreter services can be accessed via Interpreting New Zealand when required. Staff knew how to do so and brochures on the service were easily accessible. Staff reported interpreter services were rarely required due to all present residents being able to speak 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	The current strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents described annual and longer term objectives and the associated operational plans. A sample of monthly reports to the board of trustees showed adequate information to monitor performance is reported including financial performance, emerging risks and issues, occupancy and quality indicators. The service is managed by a village manager who holds relevant qualifications and has been in the role for six years. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The village manager was unavailable for this audit, however the organisation's operations manager, clinical quality manager and the care manager were all available for interview. They confirmed knowledge of the sector, regulatory and reporting requirements. The service holds contracts with the DHB for respite, hospital, rest home and dementia level residential care services. 85 residents were receiving services under the contracts (36 receiving hospital level care, 36 rest home care level and 13 in the dementia unit) at the time of audit. The prospective purchaser, Metlifecare is an established New Zealand company which owns and operates a large portfolio of retirement villages and care homes. Governance is provided by a six person board of directors. Day to day operations and leadership is provided by

		an experienced executive team. The team includes a CEO and a clinical nurse director who have many years' experience in the NZ aged care sector. They have developed and documented integration plans which demonstrate the extent of due diligence completed prior to offering a sale and purchase agreement. Each site has been visited, and Metlifecare have identified all areas where the two organisations are the same, similar or different. An integration team has been appointed to facilitate a smooth transition for staff, residents and relatives at each site. Interview with the clinical nurse director confirmed their knowledge and understanding of the contractual and sector responsibilities and requirements for the provision of residential age care services. Metlifecare are in receipt of the current funding agreements for each of the facilities they are acquiring and understand their role and responsibilities in upholding these agreements. Each DHB and the MoH have been informed about the pending change of ownership.
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	Selwyn Park Village have established systems for covering senior staff and management absences. Staff report these arrangements work well. Interview with the prospective purchaser confirmed there is no intention to implement changes in service management in the short to medium term. Metlifecare have qualified and experienced facility managers who can cover unexpected staff absences.
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	The current organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular patient satisfaction survey, monitoring of outcomes, clinical incidents including infections and pressure injuries. Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and

		discussed at the clinical team meeting, quality and risk team meetings, organisational team meetings and staff meetings. Staff reported their involvement in quality and risk management activities through audit activities. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. The most recent survey showed the need for replacement kettles in the tea making bays. Replacements have been purchased. Current policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. The operations manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies and was familiar with the Health and Safety at Work Act (2015) and requirements have been implemented. Metlifecare have access to the Selwyn Care group's policies and procedures and these are currently being reviewed and compared with the Metlifecare policy set to determine areas of excellence, where policies are the same or where these can be merged. The intention is to gradually introduce all staff to the reviewed Metlifecare policies over the first six months of ownership. A pre audit review of Metlifecare policies confirmed that the existing policy set meets the requirements of the current standards, all known legislative, contractual and regulatory requirements. Metlifecare has established quality and risk management systems which demonstrate a commitment to continuous quality improvement. This includes the development and review of quality and risk management plans and determining measurable quality indicators. . Progress with meeting quality indicators is reviewed by the organisational clinical governance group and the executive management team. The organisation also compares its overall quality data with five other New Zealand age care providers, one of whom is Selwyn Care. This sharing of performance information between Selwyn Care and Metlifecare senior executive team members conducting site visits prior

		to the signing of the sales and purchase agreement, confirms that the purchaser is fully informed about the positive and potential growth areas for each site. Metlifecare has documented transition plans that include communication strategies about the change of ownership to all involved parties, and allocate responsibilities to key personnel for identifying and managing areas of concern or gaps that require immediate attention. The organisation is proactive in ensuring a smooth change of ownership and identifying areas that can be improved upon in each facility.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to the care manager or village manager. The quality and risk manager described essential notification reporting requirements, including for pressure injuries. There have been five events at Selwyn Park Village that required notification under section 31 since the previous audit. Metlifecare has proven systems for reporting and recording adverse events. Interview with the clinical nurse director and review of company documents confirmed the purchaser understands their responsibilities for preventing, managing and reporting notifiable events to the relevant regulatory bodies.
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 management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.

		Comprehensive staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and a performance review after four, eight and twelve weeks. These are then completed annually. Continuing education is planned on an annual basis, including mandatory training requirements. All care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. A staff member is the internal assessor for the programme. Staff working in the dementia care area have all completed the required education. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of a four weekly roster cycles confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate and there is 24/7 RN coverage in the hospital. The prospective provider demonstrates knowledge and understanding about NZ employment legislation. The integration plan describes no expected changes to the current configuration of staff at Selwyn Park Village. The interviewee stated there was an existing alignment of policy and practices for staff hours and skill mix between the two organisations. Metlifecare will introduce their human resources management systems for recruitment, performance management, and

		professional development and payroll services after takeover. All existing staff will be offered an employment agreement. Additionally, an 'Integration Team' is being set up to assist Selwyn staff to transition to the 'Metlife way'. It was stated that integration team members will focus on supporting safe and effective clinical service delivery and reinforcing clinical governance. Metlifecare have identified any individuals employed by Selwyn Care who hold positions which already exist in their organisation that may result in two people having the same role and responsibility. At this time there is no stated intention to downsize or eliminate key personnel after taking over ownership. The sale and purchase agreement includes a safety clause about the number of RNs employed for each site. Metlifecare have recently recruited a clinical workforce strategist to proactively focus on the mitigation of aged care workforce shortages.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The resident's name, date of birth and National Health Index (NHI) number are used as the unique identifier on all residents' information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were electronic current and integrated with GP and allied health service provider notes. Records were legible with the name and designation of the person making the entry identifiable. Archived records are held securely on site and are readily retrievable using a cataloguing system. Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit. Electronic records are stored in a secure portal
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent,	FA	Residents are admitted to Selwyn Park when they have been assessed by the local Needs Assessment and Service Coordination (NASC) Service and confirmed to require the services that Selwyn

equitable, timely, and respectful manner, when their need for services has been identified.		Park provide. Prospective residents and/or their families are encouraged to visit the facility prior to admission and meet with the facility manager (FM) or the care manager (CM). They are also provided with written information about the service and the admission process. Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic details, assessments, and signed admission agreements in accordance with contractual requirements. All files reviewed of residents in the secure unit, contained activated EPOAs, specialist authorisations for placement and an admission agreements signed by the EPOA.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Exit, discharge, or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the Northland District Health Board's (NDHB) 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident, and the family. At the time of transition between services, appropriate information, including medication records and the care plan is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed transfer was managed in a planned and co-ordinated manner.
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.	PA Low	The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function

		they manage. Two recent medication events whereby residents' medication was not available at weekends is an area requiring attention. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by an RN against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request. Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries. The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range. Good prescribing practices noted included the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review was consistently recorded on the electronic medicine chart. There were seven residents who self-administer medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner. Medication errors are reported to the RN and CM and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified. Standing orders are not used at Selwyn Park.
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 out to an external provider. The service is provided on site by a kitchen manager and a cook and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and was reviewed by a qualified dietitian on 24 September 2021. Recommendations made at that time have

		been implemented. An updated food control plan is in place. A verification audit of the plan took place on 17 August 2021. Five areas requiring corrective action were identified. These were addressed and signed off 18 September 2021. The plan was verified for 12 months. All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation and guidelines. Food temperatures, including for high-risk items, are monitored appropriately, and recorded as part of the plan. The cook has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training. A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available. Evidence of resident satisfaction and dissatisfaction with meals was verified by resident interviews, satisfaction surveys and from residents' meetings minutes. Any areas of dissatisfaction were responded to by the kitchen manager, who attempts to deal with all areas of dissatisfaction; however, this remains ongoing. Fifteen of the 17 residents interviewed reported that the meals were 'lovely', two were dissatisfied. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There were sufficient staff on duty in the dining rooms at mealtimes to ensure appropriate assistance was available to residents as needed. Residents in the secure unit always have access to food.
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	If a referral is received, but the prospective resident does not meet the entry criteria or there is no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in

		consultation with the resident and whānau/family. Examples of this occurring were discussed with the CM. There is a clause in the access agreement related to when a resident's placement can be terminated.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	On admission, residents of Selwyn Park are initially assessed using a range nursing assessment tools, such as pain scale, falls risk, skin integrity, nutritional screening, and depression scale, to identify any deficits and to inform initial care planning. Within three weeks of admission residents are assessed using the interRAI assessment tool, to inform long term care planning. Reassessment using the interRAI assessment tool, in conjunction with additional assessment data, occurs every six months or more frequently as residents changing conditions require. In all files reviewed initial assessments were completed as per the policy and within 24 hours of admission. InterRAI assessments are completed within three weeks of admission and at least six monthly unless the resident's condition changes. Interviews, documentation, and observation verified the RNs are familiar with requirement for reassessment of a resident using the interRAI assessment tool when a resident has increasing or changing need levels. All residents have current interRAI assessments completed by trained interRAI assessors on site. InterRAI assessments are used to inform the care plan. The physiotherapist visits four hours per week and attends to residents' physiotherapy needs, plus does manual handling training for staff. A contracted podiatrist visits every six weeks to provide foot care to residents.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. In particular, the needs identified by the interRAI assessments are reflected in the care plans reviewed. Care plans evidenced service integration with progress notes, activities

		note, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans. Residents' files reviewed in the secure unit had behaviour management plans and management strategies in place, that included the use of de-escalation strategies to de-escalate behaviours.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Documentation, observations, and interviews verified the care provided to residents was consistent with their needs, goals, and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs.
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.	PA Low	The activities programme is provided by a diversional therapist and three activity assistants. The programme in the secure unit is provided seven days a week, whilst the programme in the rest home and hospital is available for five days a week. A social assessment and history are undertaken on admission to ascertain residents' needs, interests, abilities, and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated regularly and as part of the formal care plan review every six months. Residents' files reviewed in the secure unit, evidence a 24-hour activity plan that includes the residents' past lifestyle patterns. The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals, ordinary patterns of life and include normal

		community activities. Individual, group activities and regular events are offered. Examples included Thai Chi, exercise programmes, walking programme, gardening, mini golf visiting entertainers, quiz sessions and daily news updates. Several volunteers assist implementing the programme. Covid-19 restrictions have impacted on the activities programme being offered at Selwyn Park with visits, entertainers, outings and the use of volunteers being suspended while restrictions are in place. The activities programme is discussed at the residents' meetings and minutes indicate residents' input into the activities being offered is sought and responded to. Resident and family satisfaction surveys demonstrated satisfaction and that information is used to improve the range of activities offered. Residents interviewed confirmed they find the programme meets their needs. Van outings are enjoyed by residents and at times when Covid-19 restrictions are not in place, outings can occur up to three times a week. The second van that had wheelchair capability was sold over a year ago and has not been replaced. This restricts the opportunity for outings to those residents dependent on a wheelchair for mobility. This is an area requiring attention.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN. Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. The RN documents evaluations. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples were sighted of acute care plans being consistently reviewed for infections, pain, and weight loss, with progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans, were evaluated each time the dressing was changed. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.

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	Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a newly appointed main medical provider, residents may choose to use another medical practitioner. If the need for other non-urgent services is indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to older persons' mental health services. Referrals are followed up on a regular basis by the RN or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.
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	Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur. There is provision and availability of protective clothing and equipment, and staff were observed using this.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A current building warrant of fitness (expiry date 1/7/2022) was publicly displayed. Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment was current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. The environment was hazard free and resident safety was promoted.

		External areas are safely maintained and were appropriate to the resident groups and setting. Staff confirmed they know the processes they should follow if any repairs or maintenance are required and that requests are actioned. Residents and family members were happy with the environment. Metlifecare have stated an intention to increase the aged care complement within their retirement village group. They are committed to ensuring that each facility complies with building and environmental regulations and that planned and reactive maintenance continues to occur.
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 numbers of accessible bathroom and toilet facilities throughout the facility. This includes most hospital care beds with individual ensuites, and most rest home care rooms have their own toilets with adequate showers available. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. Care is needed when using the nine swing beds for transition to hospital level care for residents to ensure their equipment needs can be adequately responded to. All bedrooms provide single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed. There is room to store mobility aids, wheelchairs and mobility scooters. Staff and residents reported the adequacy of bedrooms.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining	FA	Communal areas are available for residents to engage in activities. The dining, activity and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs.

needs.		
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	Laundry is undertaken on site in a dedicated laundry by a well-trained laundry team. Dedicated laundry staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner. There is a small, designated cleaning team who have received appropriate training. These staff undertake the New Zealand Qualifications Authority Certificate in Cleaning (Level 2), as confirmed in interview of cleaning staff and training records. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers. Cleaning and laundry processes are monitored through the internal audit programme.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	Policies and guidelines for emergency planning, preparation and response were displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service on the 2 May 2012. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 27 November 2021. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures. Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones, torches, blankets, glow sticks and gas BBQ's were sighted and met The National Emergency Management Agency recommendations for the region. A 30,000 litre water storage tank is located at the complex, and there is a generator on site. Emergency lighting is regularly tested. Call bells alert staff to residents requiring assistance. Informal call

		system audits are completed on a regular basis and print outs of call response times are electronically recorded. Residents and families reported staff respond promptly to call bells. Appropriate security arrangements are in place. Doors and windows are locked at night-time and a security company checks the premises at night.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows. Heating is provided by a combination of underfloor heating in the hospital wing, heat pumps and electric heaters in residents' rooms in the communal areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	Selwyn Park provides a managed environment that minimises the risk of infection to residents, staff, and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, developed at organisational level with input from the CM. The infection control programme and manual are reviewed annually. A Covid-19 pandemic plan is in place, as is an outbreak management plan. The RN with input from the CM is the designated infection control coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the CM, and tabled at the staff and RN meetings. Infection control statistics are entered in the organisation's electronic database and benchmarked within the organisation's other facilities. The organisation's clinical quality manager and the operations manager are informed of any IPC concern. Signage at the main entrance to the facility requests anyone who is or has been unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about how long

		they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities. During the Covid-19 restrictions, visiting times and numbers are reduced. All visitors and staff who enter the site are temperature checked.
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	The infection control coordinator (ICC) has appropriate skills, knowledge, and qualifications for the role; however, has been in this role for only a short time and is being assisted by the CM. The ICC was to have attended training on IC with the IC nurse at the NDHB, however this was cancelled in 2021 due to Covid-19 restrictions. The ICC has access to an external IC advisory company to ensure best practice IC standards are maintained. Training with all the organisation's ICCs occurred in June 2021. Well-established local networks with the infection control team at the DHB are available. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections. The ICC and CM confirmed the availability of resources to support the programme and any outbreak of an infection.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	The IPC policies reflected the requirements of the IPC standard and current accepted good practice. Policies were reviewed within the last year and included appropriate referencing. Care delivery, cleaning, laundry, and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves, as was appropriate to the setting. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.
Standard 3.4: Education	FA	Priorities for staff education are outlined in the infection control

The organisation provides relevant education on infection control to all service providers, support staff, and consumers.		programme annual plan. Interviews, observation, and documentation verified staff have received education in IPC at orientation and ongoing education sessions. Education is provided online, by the CM and the ICC. Content of the training was documented and evaluated to ensure it was relevant, current, and understood. A record of attendance was maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. Training on Covid-19, the use of personal protective equipment (PPE) and donning and doffing of PPE has been presented at Selwyn Park. Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell and increasing fluids during hot weather.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and skin infections. When an infection is identified, a record of this is documented in the resident's clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs. The ICC and CM review all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via RN and staff meetings and at staff handovers. Surveillance data is entered in the organisation's electronic infection database. Graphs are produced that identify trends for the current year, and comparisons against previous years. Data is benchmarked internally within the group's other aged care providers. A good supply of personal protective equipment is available. Selwyn Park has processes in place to manage the risks imposed by Covid-19.

Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility. The coordinator was not available for interview but the care manager demonstrated a sound understanding of the organisation's policies, procedures and practice and the role and responsibilities of all staff. On the day of audit, seven residents were using restraints (bed rails and one lap belt) and one resident was using an enabler, which were the least restrictive and used voluntarily at their request. A similar process is followed for the use of enablers as is used for restraints. Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, files reviewed, and from interviews with staff. The care manager also confirmed a restraint free strategy is currently being implemented.
Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.	FA	The restraint approval group, made up of the coordinator, assistant care manager, therapist, and a general practitioner, are responsible for the approval of the use of restraints and the restraint processes. It was evident from review of restraint approval group meeting minutes, residents' files and interviews with the care manager that there were clear lines of accountability, that all restraints have been approved, and the overall use of restraints is being monitored and analysed. Evidence of family/whānau/EPOA involvement in the decision making was on file in each case. Use of a restraint or an enabler is part of the plan of care.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	Assessments for the use of restraint were documented and included all requirements of the Standard. The RN undertakes the initial assessment with the restraint coordinator's involvement, and input from the resident's family/whānau/EPOA. The care manager described

		the documented process. Families confirmed their involvement. The general practitioner is involved in the final decision on the safety of the use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the resident's safety and security. Completed assessments were sighted in three records of residents who were using a restraint.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The use of restraints is actively minimised, and the restraint coordinator described how alternatives to restraints are discussed with staff and family members (e.g., the use of sensor mats and low beds). When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details. Access to advocacy is provided if requested and all processes ensure dignity and privacy are respected. A restraint register is maintained, updated every month and reviewed at each restraint approval group meeting. The register was reviewed and contained all residents currently using a restraint and enough information to provide an auditable record. Staff have received training in the organisation's policy and procedures and in related topics, such as positively supporting people with challenging behaviours. Staff spoken to understood that the use of restraint is to be minimised, and how to maintain safety when in use.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	Review of residents' files showed that the individual use of restraints is reviewed and evaluated during care plan and interRAI reviews, initially at one month then six monthly restraint evaluations, as well as at the restraint approval group meetings. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process. The evaluation covers all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation completed

		as required.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The restraint committee undertakes a six-monthly review of all restraint use which includes all the requirements of this Standard. Six monthly restraint meetings and reports are completed, and individual use of restraint use is reported to the quality and staff meetings. Minutes of meetings reviewed confirmed this included analysis and evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use, the competency of staff and the appropriateness of restraint / enabler education and feedback from the doctor, staff and families. A six-monthly internal audit also informs these meetings. Any changes to policies, guidelines, education and processes are implemented if indicated. Data reviewed, minutes and interviews with the care manager confirmed that the use of restraint has been reduced over the last year and with the implementation of the restraint free environment strategy recently they hope to significantly reduce those numbers in the future.

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 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Low	There have been two recent medication incidents whereby residents’ medications have not been available at weekends. One related to a resident being discharged from NDHB late on a Friday afternoon, after the pharmacy had closed, and the other related to a medication not being re-ordered on a Friday and running out over the weekend. The first incident saw the resident receiving the required medication using onsite supplies, however the second resident did not get the eye drops as prescribed until the Monday. The facility’s contracted pharmacy is not open late on Friday or over the weekends. The pharmacist is available to supply afterhours, however this does incur a cost. In both the above instances an afterhours supply was not requested. This risk has been identified by Selwyn Park. A	Two recent medication events identified access to afterhours medications requires attention.	Provide evidence a process has been implemented to ensure residents always have access to their prescribed medications. 30 days

		corrective action plan is in place to address how this deficit in service provision is to be managed.		
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.	PA Low	The facility used to have two vans, one being wheelchair accessible, that enabled residents in wheelchairs to go out and participate in community activities that are meaningful to them. The wheelchair accessible van was sold last year and has not been replaced. There is no access to a rental wheelchair accessible van to meet the needs of residents in wheelchairs.	Residents in wheelchairs are unable to go on outings, as there is no wheelchair accessible van available or accessible at Selwyn Park.	Provide evidence wheelchair bound residents have access to a wheelchair accessible van, to enable participation in outings. 180 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.