

Metlifecare Limited - Selwyn Sprott Village

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 Sprott Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 8 December 2021 End date: 9 December 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:	81

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

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

Selwyn Sprott Village provides rest home, dementia and hospital level care under an agreement with their district health board (DHB) Capital and Coast (CCDHB) for up to a maximum of 90 residents.

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 Metlifecare's 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 facility's 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 management, staff and a general practitioner (GP). All the interviewees spoke positively about the care provided.

There have been no significant changes to the services provided or the facility since the previous certification audit in January 2021. The corrective actions required as a result of that audit were confirmed as rectified.

This provisional audit revealed three areas requiring improvement relating to the resident and family satisfaction survey, ensuring that residents who use wheelchairs for mobility have access to transport to support participation in recreational outings and that all service delivery plans reflect residents' required support/interventions.

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 Sprott Village. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

Selwyn Sprott Village provides services in a manner that respects the choices, personal privacy, independence, individual needs, and dignity of residents. Staff were noted to be 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 families 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 management process is clearly described in policy. Residents and relatives are advised on entry to the home about the processes for raising concerns or complaints. The service was managing complaints fairly and openly.

Organisational management

The prospective provider has a documented integration and transition plan which was reviewed and discussed during interview. The plan outlines objectives for a smooth transition and showed that the prospective provider has completed due diligence in considering all necessary matters related to acquiring the facility and its operations. The prospective purchaser demonstrated knowledge and understanding about all the requirements for delivering residential rest home, hospital and dementia care to older people under NZ legislation, these standards and funding agreements. The new provider plans to gradually introduce and transition their quality, risk and human resources systems into the facility.

The current business, quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation which are reviewed for progress annually by the owner/operators. The current manager is on site five days a week with at least one other registered nurse (RN) on site to oversee the clinical care of residents.

Selwyn Care Limited have an established quality and risk management system which includes collection and analysis of quality improvement data. Staff are involved in monitoring service delivery and feedback is sought from residents and families. There is a system for reporting and documenting adverse events. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery. These were current and are reviewed regularly.

The appointment, orientation and management of staff adheres to good employment practices. A systematic approach to identify and deliver ongoing staff 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 integrated electronic and hard copy files.

Continuum of service delivery

Staff of Selwyn Sprott Village work 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 to facilitate the admission.

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

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

Three lifestyle support assistants provide the planned activity programme. The programme provides residents with a variety of individual and group activities and maintains their links with the community. Mobile residents use a community van to go on outings.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using an electronic system. Registered nurses and care staff administer medications, all of whom have been assessed as competent to do so.

A contracted provider provides the food service. The menu 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

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

The building is in good order, has a current building warrant of fitness and meets the needs of residents. 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 offsite at another Selwyn facility.

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.

Communal and individual spaces are maintained at a comfortable temperature.

Restraint minimisation and safe practice

The organisation has implemented policies and procedures that support the minimisation of restraint. The facility does not use restraints. Two residents were using enablers 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 an external advisory company and CCDHB. 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 and trended. Results are 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	42	0	2	1	0	0
Criteria	0	90	0	2	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Selwyn Sprott Village (Sprott) has policies, procedures, and processes 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.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Nursing and care staff interviewed understand 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.</p> <p>Advance care planning, establishing, and documenting enduring power of attorney (EPOA) requirements and processes for residents unable</p>

		<p>to consent is defined and documented where relevant in the residents' files. Staff demonstrated their understanding by being able to explain situations when this may occur.</p> <p>All residents' files reviewed in the secure unit had activated EPOAs in place. Consents for these residents are signed by the EPOA.</p> <p>Staff were observed to gain consent for day-to-day care on an ongoing basis.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>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 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.</p> <p>The chaplain at Selwyn Sprott acts as an independent advocate for residents if the resident requests this. An interview with the chaplain verified they are happy to perform this role. Any past concerns that have been presented to management have been addressed promptly and to the satisfaction of those concerned.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community when Covid-19 restrictions permit, by attending a variety of organised outings, visits, shopping trips, activities, and entertainment.</p> <p>The facility normally has unrestricted visiting hours 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. At the time of audit, visiting was restricted to limited numbers and those who had made an appointment. Protocols were in place for visitors that were not vaccinated or were unwell.</p>

<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The complaints 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.</p> <p>The complaints register reviewed showed that four complaints have been received since the provider's certification audit in January 2021 and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans showed any required follow up and improvements have been made where possible. The village care manager (VCM) is responsible for complaints management and follow up, with assistance from the clinical quality manager if needed.</p> <p>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.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Residents (seven) and family members (five) of residents when interviewed reported 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 around the facility, together with brochures on the advocacy services, information on how to make a complaint and feedback forms.</p> <p>The prospective provider is aware of their obligations to comply with the Health and Disability Services Consumers' Rights Code</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>Residents and their family members confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality, and choices.</p> <p>Staff understood the need to maintain privacy and were observed doing so throughout the audit, when attending to personal cares, by ensuring resident information is held securely and privately, when exchanging verbal information and during discussion with families and</p>

		<p>the GP. All but seven rooms at Selwyn Sprott are single. Three of the double rooms are occupied, two by a single person and one room is occupied by a married couple.</p> <p>Surveillance cameras are operating throughout the common areas of the facility. Signage at the front entrance notifies anyone entering the building of this fact.</p> <p>Residents are encouraged to maintain their independence by participating in community activities, regular outings to the local shops or areas of interest and participation in clubs of their choosing. This however has been stopped temporarily, due to the Covid-19 restrictions. Each resident's care plan included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>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.</p> <p>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 records.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>There were no residents who identify as Māori in Selwyn Sprott at the time of audit. Two staff members 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 at the Auckland District Health Board.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>Residents and family members of residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Residents' personal preferences required interventions and special needs were included in all care plans reviewed, for example, food likes and dislikes, allergies, and attention</p>

		to preferences around activities of daily living.
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. Two general practitioners (GPs) also expressed satisfaction with the standard of services provided to residents.</p> <p>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.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, hospice/palliative care team, psycho-geriatrician, physiotherapist, wound care specialist, community dieticians, speech language therapists, outpatient services, and education of staff. The GP confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they are supported in the training they receive and access the organisation's online mandatory training programme, their own professional networks, such as on-line forums, CCDHB and hospice training sessions to support contemporary good practice.</p> <p>Other examples of good practice observed during the audit included the number of staff who had worked at Selwyn Sprott for greater than three years. The service supported enabling continuity of care with staff remaining in either the hospital, rest home or secure dementia unit and not having to move areas, unless it is at their request. Staff</p>

		are enabled to work permanent shifts and know from week to week what duties they are working. The two GPs visit Selwyn Sprott every day during the week. They are supportive of the care the staff provide and are available by text message for afterhours medical advice.
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Residents and family members stated they were kept well informed about any changes to their own or their relative's status, were 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 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.</p> <p>Interpreter services can be accessed via the translating application on mobile phones, family members, staff and CCDHB when required. Staff reported interpreter services were rarely required. One present resident with English as a second language, uses the translator application and family members if needed.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The current provider has a five-year strategic plan which outlines the purpose, values, scope, direction and goals of the organisation. These are reflected in the Selwyn Sprott Village business plan. Annual business goals are linked to the strategic plan and reflected regular reviews. A sample of monthly reports to the organisation's head office contained adequate information to monitor performance including occupancy, staff levels, emerging risks and issues.</p> <p>The service is managed by a Village Care Manager (VCM), who is an experienced RN with relevant qualifications and management experience. They have been in the role since February 2021. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The VCM confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through completing required learning provided by the Selwyn Foundation and meeting continuing professional</p>

		<p>development requirements.</p> <p>The service holds contracts with CCDHB for rest home, hospital and dementia level care, respite and complex medical conditions. Selwyn Sprott Village has capacity for up to 90 residents. On the first day of the audit 81 residents were receiving services under the contract; 22 residents in the dementia wing, 35 residents receiving hospital level care and 24 residents receiving rest home level care, two of whom were respite residents.</p> <p>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. A sale and purchase agreement for Metlifecare to acquire six Selwyn villages / care facilities was signed on 24 November 2021. The change of ownership is anticipated to occur by the end of February 2022. This is dependent on the outcomes from the provisional audits and on obtaining approvals from the Ministry of Health, the Overseas Investment office and the Retirement Village Statutory Supervisor.</p> <p>The prospective purchaser has developed and documented integration plans which demonstrated 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.</p> <p>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.</p>
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<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>When the VCM is absent, one of the Assistant Care managers (ACMs) carries out some of the required duties under delegated authority, with assistance from the national clinical manager. During absences of key clinical staff, the clinical management is overseen by the VCM who is an RN, experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.</p> <p>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.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Low</p>	<p>The organisation has a planned quality and risk system that reflected the principles of continuous quality improvement. This includes management of incidents and complaints, internal audit activities, a regular resident satisfaction survey, monitoring of outcomes, clinical incidents including infections and pressure injuries.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the range of meetings which occur – heads of department, all staff meeting, registered nurses (RNs), night staff, and when needed meetings with staff in their individual wings. A standard agenda is used for all meetings and includes the objectives of the quality and risk management plan. Staff reported their involvement in quality and risk management activities through reporting of adverse events, internal audit activities and receiving feedback when events are reported and collated data through meetings. Relevant corrective actions are developed and implemented to address any shortfalls. Evidence of these were sighted. When trends are identified or critical incidents occur, further analysis is completed and a report is sent to the Selwyn Care clinical governance group. The national clinical quality manager is the coordinator of this committee and was interviewed during the audit.</p> <p>The organisation’s policy is to conduct an annual resident and family satisfaction surveys. The most recent survey was in 2019 and other</p>

	<p>than individual post admission surveys there has been no overall satisfaction survey of residents for the past two years. An area for improvement is identified in relation to this.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and are current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The VCM described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements.</p> <p>Metlifecare plans to gradually introduce their quality and risk system and sector standardised policies. A pre audit review of their policies and procedures showed these meet the current legislative and sector regulated requirements. Metlifecare has established processes for reviewing and updating policies as required. They have access to the Selwyn 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.</p> <p>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. These systems which include gathering and analysing site specific quality data such as reportable events, infections, complaints and resident/relative feedback will be implemented over time. Regular internal audits using the Metlifecare tools will also be phased in. Monthly summaries of quality data are benchmarked against other Metlifecare sites. 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</p>
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		<p>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.</p> <p>Metlifecare has documented transition plans that include communication strategies about the change of ownership to all involved parties and allocates 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.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>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 by the VCM to the national clinical manager.</p> <p>The VCM and clinical quality manager both described essential notification reporting requirements, including for pressure injuries. Since the provider's previous certification audit there have been five notifications of significant events made to the Ministry of Health by the VCM. These included three occasions when two residents with early stage memory loss left the facility on different occasions and later returned safe and well, a fall resulting in serious injury and a pressure injury. The national clinical manager reported that other essential notifications may be made by senior executives of the Selwyn Care Foundation at their central office. If any were made at this level for Selwyn Sprott Village during this time frame, these were not available for review.</p> <p>Part of the incident reporting system includes a critical incident review process. Examples of this were seen related to the section 31 notifications. The pressure injury notification was included in the analysis and reporting of all pressure injuries, by the clinical governance group.</p> <p>Metlifecare have well established systems for reporting and recording adverse events. Interview with the clinical nurse director and review of</p>

		<p>company documents confirmed the purchaser understands their responsibilities for preventing, managing and reporting notifiable events to relevant regulatory bodies.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Human resource 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 (12) reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>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 a three-month period.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or commenced one or more relevant New Zealand Qualification Authority (NZQA) education programmes to meet the requirements of the provider's agreement with the DHB. A staff member is the internal assessor for the programme. All staff working in the dementia care area have either completed (six of ten), are nearing completion (one of four) or have recently commenced work at Selwyn Sprott and are enrolled in the learning programme (the remaining three).</p> <p>Of the records sampled which included the ACMs, RNs, caregivers, house-keeping staff, the maintenance manager, and a member of the lifestyle coordination team, all hold relevant qualifications for their roles, and have completed learning including the sessions required to be completed during 2021. Healthcare professionals hold current registrations and are working within their scope. 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. (Note: the VCM's personnel file and records were not available on site for review.)</p>

<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>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.</p> <p>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 two week roster across all areas confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. The VCM reported that since she has been at the facility, they have only been three shifts when a position in one shift could not be filled. Otherwise, all shifts are covered when unexpected absences occur.</p> <p>At least one staff member on duty has a current first aid certificate and there is 24 hour/seven days a week (24/7). RN coverage in the hospital meets contractual requirements.</p> <p>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.</p> <p>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.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>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</p>

		<p>name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p> <p>Electronic records are stored in a secure portal.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Residents are admitted to Selwyn Sprott when they have been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service, as requiring the services Selwyn Sprott provides. Prospective residents and/or their families are encouraged to visit the facility prior to admission and meet with the Village and Care Home Manager (VCM) and the Assistant Care Managers (ACM). They are also provided with written information about the service and the admission process.</p> <p>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 detail, assessments, and signed admission agreements in accordance with contractual requirements.</p> <p>Residents' files reviewed in the secure unit had activated EPOAs in place and specialist's authorisation for placement. Admission agreements and consents are signed by the EPOA.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Exit, discharge, or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the CCDHB '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</p>

		<p>of a patient recently transferred to the local acute care facility showed transfer was managed in a planned and co-ordinated manner. The resident's family was kept informed and met the resident at the hospital.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>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.</p> <p>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.</p> <p>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. Bulk supplies are documented and reviewed.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>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.</p> <p>There was one resident who was self-administering medication at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner.</p>

		<p>Medication errors are reported to the ACMs and VCM 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.</p> <p>Standing orders are not used at Selwyn Sprott.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The contracted food service is provided on site by a cook and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian on September 24, 2021. Recommendations made at that time have been implemented.</p> <p>An up-to-date food control plan is in place. A verification audit of that food control plan was undertaken on June 30, 2021. No areas requiring attention were identified. The Food Control Plan was verified for 12 months</p> <p>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 digitally monitored appropriately, and recorded as part of the plan. The cooks and kitchen hands have completed relevant food handling training.</p> <p>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.</p> <p>Residents in the secure unit have access to food at any time night or day</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Any areas of dissatisfaction were promptly responded to. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There are</p>

		sufficient staff on duty in the dining rooms at mealtimes to ensure appropriate assistance is available to residents as needed.
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>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 ACM. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>On admission, residents of Selwyn Sprott are assessed using a range of nursing assessment tools, such as a 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.</p> <p>In all files reviewed initial assessments were completed as per the policy and within 24 hours of admission. InterRAI assessments were 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.</p> <p>All residents had current interRAI assessments completed by one of six trained interRAI assessors on site. InterRAI assessments are used to inform the care plan.</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>Plans reviewed reflected the generalised support needs of residents, and the outcomes of the integrated assessment process and other relevant information. In particular, the needs identified by the interRAI assessments. However, nine of 11 care plans reviewed did not describe fully the interventions required to meet residents' assessed needs, particularly in relation to medical conditions, short term problems and the twenty-four hour needs of residents in the secure unit. This is an area requiring attention.</p> <p>Care plans evidenced service integration with progress notes, activities note, medical and allied health professional's 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</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>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. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels/types of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>PA Low</p>	<p>The activities programme is provided by three lifestyle support assistants, one of whom is a diversional therapist. Each assistant is allocated to a designated area. Activities are offered five days a week, and in the weekend, with one assistant working on the Saturday and Sunday.</p> <p>A social assessment and history are undertaken on admission to</p>

		<p>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.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Three activities programmes operate at Selwyn Sprott, one in each of the three wings (hospital, rest home and the secure unit). Activities reflected residents' goals, ordinary patterns of life and when Covid-19 restrictions are not imposed, include normal community activities. Individual, group activities and regular events are offered. Examples included exercise sessions, baking, games, 'sing a long', crosswords, quiz sessions and daily news updates. The activities programme is discussed at the residents' meetings, however Covid-19 restrictions have prevented these occurring every month as scheduled. Meeting minutes from meetings that have occurred indicated residents' input into activities is sought and responded to. Resident and family meetings occurred twice in the secure unit in 2021, to keep residents and family members up to date with Covid-19. No residents' meetings have occurred in the hospital this year. Residents and family members of residents when interviewed confirmed they find the activities programmes meets their needs.</p> <p>There are no twenty-four-hour activities plan, that reflect aspects of the resident's life and past routines, in the files of residents in the secure unit (refer criterion 1.3.5.2).</p> <p>A community van is available for residents' outings. Due to Covid-19 restrictions van outings are continuing for residents at Selwyn Sprott, however residents are not able to get out of the van. Outings occur three times a month on a Friday and once a month on a Monday. Residents who require a wheelchair for mobility, are unable to go on outings as there is no access to a mobility van. This is an area requiring attention.</p>
Standard 1.3.8: Evaluation	FA	Residents' care is evaluated on each shift and reported in the progress

<p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>		<p>notes. If any change is noted, it is reported to the RN.</p> <p>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 care provide. Examples were sighted of wound care plans changing when the wound was not responding to the wound care regime in place, and pain management changing when the pain relief prescribed was not effective. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a 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/ACM/RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to the psychogeriatrician. Referrals were followed up on a regular basis by the ACM/RN or 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.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>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.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this. Spill kits are clearly identified and</p>

		are available in designated locations throughout the facility.
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>A current building warrant of fitness which expires on 18 July 2022 was publicly displayed.</p> <p>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. Any requests for repairs are appropriately actioned and are followed up by the VCM through the regular heads of department meetings. The environment was hazard free, residents were safe and independence is promoted.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting.</p> <p>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.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are a total of 57 bathrooms and toilets throughout the facility. This includes rooms with ensuites, shared bathrooms and staff / visitor toilets. Residents' bathrooms have appropriately secured and approved handrails, and other equipment/accessories are available to promote residents' independence.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. There are seven 'double sized' bedrooms. All other bedrooms provide single accommodation.</p> <p>Selwyn Sprott's policy on occupancy of the double-sized rooms by more than one person is that they are only for occupancy by a couple –</p>

		<p>and only where this is their choice. One of the seven double rooms is occupied by a couple who are in the room by choice. Of the other six double rooms, two are occupied by single people and the remaining four are vacant.</p> <p>Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>There is additional storage room for mobility aids, wheelchairs and mobility scooters. Staff and residents reported the adequacy of bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Communal areas are available for residents to engage in activities. There are multiple dining and lounge areas, all of which are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture in the communal areas is appropriate to the setting and residents' needs.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Laundry is undertaken on site in a dedicated laundry. 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. The annual cleaning and laundry audit has been completed, as scheduled.</p> <p>There is a small designated cleaning team who have received appropriate training. These staff are undertaking the required 'Selwyn Learn' annual training programme. They have a range of New Zealand Qualifications Authority Certificates in relevant aged care certificates. Several team members have been caregivers before moving into the house-keeping team. They confirmed in interview their completion of ongoing training, and this was supported by review of personnel and training records.</p> <p>Chemicals were stored in a lockable cupboard, in the laundry, and were in appropriately labelled containers on cleaners' trolleys during their shifts.</p>

<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Policies and guidelines for emergency planning, preparation and response are 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.</p> <p>The current fire evacuation plan was approved by the New Zealand Fire Service on the 26 March 2010. There is usually a trial evacuation every six months with a representative from the New Zealand Fire Service in attendance. The last time this occurred was in November 2019. The local fire safety officer emailed the facility in February 2020 and advised them that due to the Covid pandemic they would not be attending evacuation practices until further notice. There is annual fire and emergency competency training, and this was sighted on the training schedule and in the records reviewed. The most recent being in February 2021. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's were sighted and meet the requirements for all residents. Water storage tanks are located around the complex (two tanks: a22,000 L and a 100 L tank), and there is a generator on site. Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells. Issues with the call wiring for the system were identified and a quality improvement project was raised which has addressed these. (See Standard 1.2.3).</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined times and a security company checks the premises at night.</p>

<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and some have doors that open onto an outside garden or small patio area.</p> <p>Heating is provided by electric, wall-mounted panel heaters in residents' rooms in the communal areas.</p> <p>All areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>Selwyn Sprott 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 an external infection control advisory company. The infection control programme and manual are reviewed annually.</p> <p>One of the ACMs 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 VCM, the organisation's quality manager, and tabled at the staff and RN meetings. Infection control statistics are entered in the organisation's electronic database. The organisation's clinical governance group is informed of any IPC concern.</p> <p>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.</p> <p>Covid-19 restrictions were in place at the time of audit. Visitors are restricted and must make an appointment. Monitoring and screening of visitors occurs on entry to the facility. All residents have been vaccinated against Covid-19. All residents have either had or are</p>

		<p>planning on having the booster.</p> <p>A Covid-19 pandemic plan document provides guidance on the strategies required at the different alert or traffic light levels.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The infection control coordinator (ICC) has appropriate skills, knowledge, and qualifications for the role. The ICC has undertaken training in infection prevention and control and attended relevant study days, as verified in training records sighted. Well-established local networks with the infection control team at the CCDHB are available and expert advice from an external advisory company is available if additional support/information is required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The ICC confirmed the availability of resources to support the programme and any outbreak of an infection.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>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.</p> <p>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.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation, and documentation verified staff have received education in IPC at orientation and ongoing education sessions. Education is provided online and by suitably qualified RNs and the ICC. Content of the training was documented</p>

		<p>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 was evidence that additional staff education has been provided in response. An example of this occurred when there was a recent 'RSV' outbreak.</p> <p>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.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>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.</p> <p>The ICC reviews 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 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. Incidents of infections at Selwyn Sprott are low.</p> <p>An RSV outbreak in the secure unit in August this year involved 14 residents and five staff. The unit was placed into lockdown. Laboratory results identified three residents as positive and three negative. All residents were not tested. The outbreak lasted for a month. Public health was notified and emails verified complimentary remarks in regard to how well the outbreak was managed.</p> <p>A good supply of personal protective equipment is available. Selwyn Sprott has processes in place to manage the risks imposed by Covid-</p>

		19.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>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.</p> <p>The restraint coordinator (RC) is one of the ACMs. They provide support and oversight for enabler use in the facility. There is a no restraint policy in the facility and the RC demonstrated a sound understanding of the organisation's policies, procedures and practice and their role and responsibilities.</p> <p>On the day of audit, there were no residents using restraints. There were two residents who were using enablers, which were the least restrictive option for safety and were used voluntarily at each resident's request. An assessment, consent and monitoring process are followed for the use of enablers, similar to that which was followed when restraints were used at the facility.</p> <p>If restraints are requested by family members or EPOAs on behalf of a resident, their reasons for requesting this are listened to and discussed. Alternatives to the requested restraint are trialled until a suitable safe process/other support is found which provides safety and freedom of movement. This was evident on review of a range of staff meeting minutes, as previously noted in this report, and through interviews with staff members.</p> <p>The use of all enablers used for resident is reported through the RC to the clinical governance group. The process for assessing, monitoring and supporting the use of enablers and not using restraints was confirmed in the files reviewed and from interview with staff members (ACM/RC, RNs and caregivers).</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.5</p> <p>Key components of service delivery shall be explicitly linked to the quality management system.</p>	PA Low	<p>There is evidence of a quality and risk management system as documented by Selwyn Care Ltd. This includes the reporting of adverse events, monitoring of resident outcomes, infections and other clinical indicators, health and safety, and resident and family satisfaction. A post admission survey and resident satisfaction survey are included in the suite of internal audits. These are both completed by staff members.</p> <p>Over 2020 and 2019, the resident and family meetings have occurred, these have been infrequent due to the restrictions of Covid 19 Alert levels and requirements for managing the potential risk of residents' being exposed to infection.</p> <p>Selwyn Care Ltd has previously engaged an external organisation to administer their</p>	<p>Since the last satisfaction survey was completed in 2019, there has been no formal satisfaction survey completed for residents and family members.</p>	<p>A satisfaction survey which can be completed by residents and / or with family involvement is completed to meet the organisation's own requirements, and the requirements of this Standard.</p> <p>60 days</p>

		<p>satisfaction surveys and to collate, analyse and report on the results. In 2019 that company changed ownership and since then there has been no resident satisfaction survey completed.</p> <p>This has resulted in very feedback being received and analysed from residents and family/whanau at Selwyn Sprott Village.</p>		
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA</p> <p>Moderate</p>	<p>Eleven files were reviewed and nine of these did not describe fully the required support the residents' needed to meet their assessed needs. This was a care plan documentation issue, around a planned approach to care. Progress notes, interviews and observations verified the residents were receiving the care they required.</p> <p>Residents with congestive heart failure had no documentation in the care plan advising of the nursing strategies required to detect a deterioration in heart failure. Residents on anticoagulants had no strategies documented to identify observations required to identify potential bleeds. A resident with a history of bowel cancer, had no strategies documented to observe for potential recurrence. A resident with increased peripheral oedema, had medication commenced, however no short-term/acute care plan was initiated to identify actions required to monitor for its effectiveness. Residents' files reviewed in the secure unit had no twenty-four-hour plan in place that identified the residents' twenty-four-hour needs, based on previous</p>	<p>Care plans do not always describe the nursing interventions required to meet the residents' assessed needs.</p>	<p>Provide evidence that the residents' care plans describe fully the required support the residents' needs to meet their assessed needs. Residents in the secure unit have a twenty-four-hour care plan in place that addresses previous lifestyle patterns.</p> <p>90 days</p>

		lifestyle patterns.		
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	PA Low	<p>Residents of Selwyn Sprott go out on regular van trips using a community van. Interviews identify the van has no ability to transport residents in wheelchairs. There is a disabled taxi service that offers transport for residents in wheelchairs but use of these is restricted as they are prebooked for regular clients in the community and have minimal time available for additional hire. Residents in wheelchairs are therefore unable to go out on a regular basis, as evidenced by three residents interviewed.</p>	<p>Residents in wheelchairs are unable to go out in a van trip as access to the disabled taxi is limited due to the hours it is available.</p>	<p>Provide evidence that residents in wheelchairs have access to community activities if they choose.</p> <p>180 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, there 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.