

# Selwyn Care Limited - Ivan Ward Centre

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## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

<b>Legal entity:</b>	Selwyn Care Limited
<b>Premises audited:</b>	Ivan Ward Centre
<b>Services audited:</b>	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 8 April 2021      End date: 9 April 2021
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	85

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Selwyn Ivan Ward is part of The Selwyn Foundation Group. The facility is certified to provide rest home and hospital (geriatric and medical) and dementia level care for up to 90 residents. On the days of audit there were 85 residents.

The care manager oversees the service with the support of the assistant care manager, village manager and organisational managers. Residents, relatives, and the general practitioner interviewed spoke positively about the service provided. Improvements have been made since the last audit including embedding of the 'neighbourhood' model that encourages residents to be as independent as possible.

This unannounced surveillance audit was conducted against a subset of the Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, family, management, staff, and a general practitioner.

The service has addressed one of the two previous audit shortfalls around care plan documentation. There continues to be a shortfall around care implementation in relation to neurological observations.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The service has a culture of open disclosure. Families are regularly updated of residents' condition including any acute changes or incidents. Complaints processes are implemented and managed in line with the Code. Residents and family interviewed verified ongoing involvement with the community.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Services are planned, coordinated and are appropriate to the needs of the residents. The village and care manager are responsible for the day-to-day operations along with the assistant care manager.

Goals are documented for the service with evidence of regular reviews. A quality and risk management programme is in place. Data is collected, analysed, and discussed and changes made as a result of trend analysis. Quality improvement plans show evidence of resolution of issues when service shortfalls are identified. Meetings are held to discuss quality and risk management processes and results. Health and safety policies, systems and processes are implemented to manage risk.

Appropriate employment processes are adhered to. An education and training programme is established and implemented. The roster provides sufficient and appropriate staff cover for the effective delivery of care and support.

## Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Service information is provided to residents and family on admission to services. The service utilises a computer-based care planning and progress note system. Resident records reviewed provided evidence that the registered nurses utilise the interRAI and other electronic assessments to assess, plan and evaluate care needs of the residents. Care plans are developed in consultation with the resident and/or family. Care plans demonstrate service integration and are reviewed at least six-monthly. Resident files include three monthly review by the general practitioner. There is evidence of other allied health professional input into resident care.

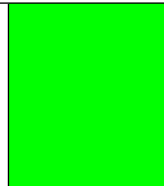
Medication policies reflect legislative requirements and guidelines, and medications are recorded using an electronic medication management system. All staff responsible for administration of medicines completes education and medicines competencies. The medicines records reviewed included documentation of allergies and sensitivities and are reviewed at least three-monthly by the general practitioner/nurse practitioner.

A varied activities programme is in place for the rest home, hospital, and secure unit residents. The programme includes community visitors and outings, entertainment and activities that meet the recreational preferences and abilities of the residents.

The menu is designed and reviewed by a registered dietitian and all meals are cooked on site (in a commercial kitchen) by an external contractor. Residents' individual needs are identified. There is a process in place to ensure changes to residents' dietary needs are communicated to the kitchen. Regular audits of the kitchen occur.

## Safe and appropriate environment

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



Standards applicable to this service fully attained.

The service displays a current building warrant of fitness. Furniture and fittings are selected with consideration to residents' abilities and functioning.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.

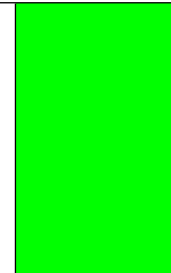


Standards applicable to this service fully attained.

The service has a policy of restraint minimisation. The service is restraint and enabler free with other interventions used to support residents when required. Staff regularly receive education and training around restraint minimisation and the management of challenging behaviour.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.



Standards applicable to this service fully attained.

The type of surveillance of infections undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated, and reported to relevant personnel in a timely manner. There have been no outbreaks since the previous audit.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	16	0	0	1	0	0
<b>Criteria</b>	0	42	0	0	1	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>Managers and staff interviewed included the following: four managers including the village manager, care manager, assistant care manager and clinical quality manager; three registered nurses (including one identified as a senior registered nurse), four care partners, two house leads (care partners) from a range of suites; the diversional therapist, cook, and student nurse.</p> <p>The service has a complaints policy that describes the management of the complaints process. Staff interviewed were able to describe the process around reporting complaints.</p> <p>A total of nine complaints were received in 2020 and two in 2021 year to date. There were no trends identified. Two complaints reviewed confirmed that a comprehensive follow up of all complaints is logged with complaints being discussed in staff meetings. All complaints received have been documented as resolved with appropriate corrective actions implemented.</p> <p>The Ministry requested follow up against aspects of a complaint that included Quality and Risk Management Systems – wound care policy and Human resource management – staff training on wound care/policy. There were no identified issues in respect of this complaint.</p> <p>Interviews with residents and relatives confirmed that they feel comfortable in bringing up concerns with the registered nurses (RNs) and management team.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Interviews with residents (seven including three from the rest home and four from the hospital), and relatives (four from the dementia unit) confirmed that they feel comfortable in bringing up concerns with the registered nurses (RNs) and management team.</p> <p>There is an accident/incident reporting policy to guide staff in their responsibility around open disclosure. Staff are required to record family notification when entering an incident into the system. All 24 incident reports reviewed in 2021 met this requirement. Family members interviewed confirmed they are notified following a change of health status of their family member. There is an interpreter policy in place and contact details of interpreters are available.</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>	<p>FA</p>	<p>Selwyn Ivan Ward is part of The Selwyn Foundation Group. The facility is certified to provide rest home and hospital (geriatric and medical) and dementia level care for up to 90 residents. Of the 90 beds, 72 are identified as being dual purpose rest home or hospital, and there are eighteen dementia beds. On the days of audit there were 85 residents with 20 residents receiving rest home level care, 47 were receiving hospital care, and 18 receiving secure dementia care. All residents were on the age-related care contract (ARCC).</p> <p>Selwyn Ivan Ward is a newly built facility within the Selwyn Village which was opened November 2018. The Selwyn Foundation has an overarching five-year strategic plan 2018 to 2022, which includes the model of care 'The Selwyn Way' which underpins how the Selwyn Foundation provides services within the context of its mission. There is a Selwyn Ivan Ward business plan 2020-2021. The business plan is reviewed quarterly by the village and care managers at the performance appraisal/coaching session for the care manager. The plan was reviewed as planned.</p> <p>Selwyn Ivan Ward is managed by an experienced care manager who has had 19 years' experience in aged care including three years' experience at Selwyn Village as care manager. The care manager has previously worked for five years in a psychogeriatric unit in the district health board. The assistant care manager is newly appointed and has a background in home and community services. There are two senior registered nurses and a village manager who also provide support.</p> <p>All managers and senior RNs have maintained at least eight hours of professional development activities related to managing an aged care facility.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has</p>	<p>FA</p>	<p>An established quality and risk management system has been fully implemented. The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. The service's policies are reviewed at a national level by the clinical</p>

<p>an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>governance group with input from facility staff every two years or as required. Clinical guidelines are in place to assist care staff. There is a wound management policy that was last reviewed in February 2020. The 2020 and 2021 audit schedule includes the need to complete a pressure injury and wound management audit. The last audit was sighted as having been completed as per schedule in December 2020. The care manager, assistant care manager and RNs interviewed were all able to describe management of pressure injuries and wounds as per policy.</p> <p>Clinical indicators are benchmarked against other Selwyn facilities and other providers. Quality improvement plans (QIPs) are developed when service shortfalls are identified, and these are monitored by group office. Quality and risk performance is reported across facility meetings, including staff meetings (that include all aspects of the quality programme), and registered nurse (RN) meetings. Additional meetings include health and safety meetings with these also held monthly. The two health and safety representatives interviewed were able to describe their role in the service as per policy and legislation. They attend a village health and safety meeting facilitated by the overarching village health and safety officer. There are daily huddles with these documented, and a clinical review with staff held on Friday to catch up and plan prior to the weekend. Minutes are documented for all meetings.</p> <p>There are two monthly resident meetings with family invited to attend. A review of meeting minutes shows that these are well attended. The care manager also talks with residents and family who are in the neighbourhoods during the week at the dining table to get feedback.</p> <p>There is an expectation that annual resident and relative surveys are completed with results communicated to residents and staff. The surveys were completed just prior to the certification audit for 2021 noting that a decision was made not to circulate a survey in 2020.</p> <p>Risk management, hazard control and emergency policies and procedures are in place. The risk register is updated monthly, and as new risks emerge with new risks escalated to the organisational risk committee with monthly reports then to the Board. There are procedures to guide staff in managing clinical and non-clinical emergencies. Staff interviewed were all able to describe how to respond in the event of an emergency. Falls prevention strategies are in place including individual and group exercise programme; meeting individual toileting needs; sensor mats; use of perimeter guard mattresses; increased monitoring; identification and meeting of individual needs.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are</p>	<p>FA</p>	<p>There is an incident/accident reporting policy that includes definitions and outlines responsibilities including: immediate action, reporting, monitoring, corrective action to minimise and debriefing. Individual incident/accident reports are completed for each incident/accident with immediate action noted and any follow-up action required.</p> <p>A review of 24 incident/accident forms (a sample from 2021 records) identified that forms are fully completed and include follow-up by a registered nurse. Neurological observations evidence that they had been consistently completed for 9 of the 13 unwitnessed falls reviewed as per policy (link 1.3.6.1). The care manager and senior</p>

<p>systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>registered nurses are involved in the adverse event process and all incidents showed that improvements were considered both for the resident concerned and the service if required.</p> <p>The service maintains a separate file for all critical and more serious events. Two of the events (pressure injuries) required a section 31 report and these were documented. All of the critical/more serious events documented an in-depth review and follow-up. There is a debriefing process for all critical incidents that includes a staff debrief and a review of the incident at the Clinical Governance Group.</p> <p>There have been no infectious outbreaks at the facility since the last audit.</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>There are comprehensive human resources policies in place. Six staff files reviewed (the assistant care manager, three RNs [including one senior RN], and two care partners) included a comprehensive recruitment process including: reference checking, signed employment contracts and job descriptions, completed orientation programmes and annual performance appraisals. A register of registered nursing staff and other health practitioner practising certificates is maintained.</p> <p>The orientation programme provides new staff with relevant information for safe work practice. There is an implemented annual education and training plan that exceeds eight hours annually. The Selwyn Foundation have an online interactive video and quiz training programme. The training plan is implemented using a mixture of electronic and on-site training including toolbox talks. There is an attendance register for each training session and an individual staff member record of training. Staff have had training in 2020 and 2021 around wound management as per the reviewed policy.</p> <p>There are 11 staff who regularly work in the dementia unit. All who work in the dementia unit have completed the required NZQA dementia education modules. There are also four staff who have completed level 2 Careerforce training (plus two currently in training), 11 who have completed level 3 and eight who have completed level four training with four currently in training for this level.</p> <p>Registered nurses are supported to maintain their professional competency. Six of ten registered nurses have completed their interRAI training as well as the care manager and assistant care manager. There are implemented competencies for registered nurses with these signed off as being completed in the three registered nurse files reviewed.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive</p>	<p>FA</p>	<p>A policy is in place for determining staffing levels and skills mix for safe service delivery. The care manager and a senior registered nurse are on duty Monday to Friday and on call as needed.</p> <p>On the ground floor the dementia wing has separate staffing.</p> <p>There are sufficient care partners (caregivers) rostered on duty each day to support the registered nurses and</p>

<p>timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>meet the needs of residents. Staff interviewed stated that overall, the staffing levels are satisfactory and that the managers provide good support. Residents and family members interviewed reported there are sufficient staff numbers.</p> <p>Household one (on the ground floor) has 12 of 12 beds occupied, (four rest home level and eight hospital residents). Household two (on the ground floor) has 12 of 12 beds occupied, (10 rest home level and two hospital residents). The houses are staffed together with four care partners in the morning (two full shift, one from 7 am-11 am and one from 7 am-1 pm). There are three in the afternoon shift (one full shift, one 4 pm-10 pm, one 4 pm-8 pm). There is one care partner on a full shift overnight. There is one registered nurse rostered on the morning shift. The registered nurse rostered onto houses three and four covers houses one and two when a registered nurse is not on.</p> <p>Household three (on the first floor) has nine of 12 beds occupied, (two rest home level and seven hospital residents). Household four (on the first floor) has 12 of 12 beds occupied, (one rest home level and 11 hospital residents). The houses are staffed together with five care partners in the morning (four full shift, one from 7 am-11 am). There are four in the afternoon shift (three full shift, one 4 pm-8 pm). There are two care partners on a full shift overnight with one in each house. There is one registered nurse rostered on each shift.</p> <p>Household five (on the second floor) has 12 of 12 beds occupied, (four rest home level and eight hospital residents). Household six (on the second floor) has 10 of 12 beds occupied, (10 hospital residents). The houses are staffed together with five care partners in the morning (four full shift, one from 7 am-11 am). There are four in the afternoon shift (three full shift, one 4 pm-8 pm). There are two care partners on a full shift overnight with one in each house. There is one registered nurse rostered on each shift.</p> <p>The dementia unit has 18 of 18 beds occupied. There are four care partners in the morning (three full shift, one from 7 am-11 am). There are three care partners in the afternoon shift (two full shift, one 4 pm-10 pm). There are two care partners on a full shift overnight. There is one registered nurse rostered on seven days a week for one shift per day and then the registered nurse in houses five and six covers the dementia unit as well. There is a registered nurse floating nurse who covers houses one and two and the dementia unit overnight.</p> <p>There are house leads (care partners) on the morning and afternoon shifts who support the RNs. There is a Selwyn bureau and staff at times are asked to stay on if they wish to cover a shift if someone has called in for leave at the last minute. A review of rosters confirmed that staff are always replaced when on leave.</p> <p>Staff are able to access any house easily with two lifts in place and stairs.</p>
<p>Standard 1.3.12: Medicine Management Consumers receive</p>	<p>FA</p>	<p>There are comprehensive policies and procedures (standard operating procedures) in place for all aspects of medication management, including self-administration. The RN checks all medications on delivery against the medication and any pharmacy errors are recorded and fed back to the supplying pharmacy.</p>

<p>medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>Registered nurses responsible for the administering of medications have completed annual medication competencies and annual medication education. Caregivers who act as a second checker also had a medication competency. There were no self-medicating residents on the day of audit, however self-medicating competencies and procedures for three monthly reviews and monitoring were in place should they be required. The four medication rooms were clean and well organised, all medications were in date and stored appropriately. The medication fridges have temperatures recorded daily and these are within acceptable ranges.</p> <p>Twelve medication charts were reviewed. Photo identification and allergy status was on all charts. All medication charts had been reviewed by the GP at least three-monthly. All resident medication administration signing sheets corresponded with the medication chart. All medication charts evidence full and comprehensive documentation of non-packaged regular medication orders.</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 residents' individual food, fluids and nutritional needs were met. Residents are provided with a balanced diet which meets their cultural and nutritional requirements. The food service is contracted to an external provider. The meals are cooked on site in the commercial kitchen that provides for all the facilities on the site.</p> <p>The external contractors have a summer and winter menu reviewed by a registered dietitian as per the contract and they also provide dietetic input into the provision of special menus and diets where required. A dietary assessment is completed on all residents at the time they are admitted. Residents with special dietary needs have these needs identified. Resource information on these diets is available in the kitchen and via the dietitian. Resident forums discuss food and feedback is given.</p> <p>Residents interviewed expressed satisfaction with the meals.</p> <p>Special equipment is available such as lipped plates/assist cups/grip and built-up cutlery and on observing mealtimes it was noted there were sufficient staff to assist residents including in the secure dementia unit.</p> <p>The kitchen was observed to be clean and well organised, and all aspects of food procurement, production, preparation, storage, delivery, and disposal complied with current legislation and guidelines.</p> <p>There is a current food control plan which expires January 2022.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and</p>	<p>FA</p>	<p>Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans reviewed were resident-centred. Interventions documented support needs and provided detail to guide care. The sample of care plans reviewed identified that interventions for pain management, falls prevention and chronic wound management were appropriately documented and this is an improvement on the previous audit.</p> <p>Residents and relatives interviewed stated that they were involved in the care planning process. There was evidence of service integration with documented input from a range of specialist care professionals, including the</p>

promote continuity of service delivery.		podiatrist, wound care specialist and mental health care team for older people. The care staff interviewed advised that the care plans were easy to follow. Integration of records and monitoring documents are well managed.
<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>	PA Moderate	<p>When a resident's condition changes the RN initiates a GP visit or nursing specialist referral. Residents interviewed reported their needs were being met. Family members interviewed stated the care and support met their expectations for their relative. There was documented evidence of relative contact for any changes to resident health status.</p> <p>Continence products are available and resident files include a three-day urinary continence assessment, bowel management and continence products identified for day use, night use and other management. Specialist continence advice is available as needed and this could be described by the RNs interviewed. Caregivers and RNs interviewed stated there are adequate continence and wound care supplies.</p> <p>Wound care plans are all electronic and include an assessment, wound management regime and evaluation. All documented regular review. Thirty-three wounds were documented on the day of audit: ten skin tears, fifteen chronic wounds (one resident has four cancerous lesions), seven grazes and one grade 2 pressure injury. Resident files sampled, including the grade 2 community acquired pressure injury evidenced timely referral to allied health professionals including DHB wound nurse specialist and dietitian. The shortfall regarding this identified at the previous certification audit has been resolved. Resident records reviewed identified wound and pain management. The wound care specialist is involved with eight of the chronic wounds.</p> <p>Care plans where pain and wound care was a current issue had wound and pain management strategies/interventions documented. Monitoring of pain was completed on pain assessments and via the electronic medication system. Referrals to allied health services such as wound care specialist was completed where required.</p> <p>A review of the wound policy had been recommended in connection to a complaint directed to an external provider, this was reviewed during the audit and found to be comprehensive and fit for purpose. Staff training regarding the classification of wounds had been scheduled to take place two weeks after the date of audit.</p> <p>Monitoring charts were in use and examples sighted included (but not limited to): weight and vital signs, blood glucose, pain, food, and fluid, turning charts and behaviour monitoring as required.</p> <p>Neurological observations are taken for some incidents which involve a resident having an unwitnessed fall or a hit to the head. The shortfall identified at the previous audit remains.</p>
Standard 1.3.7: Planned Activities	FA	Selwyn Ivan Ward employs one diversional therapist and one activity coordinator who both work full-time. Activities are provided seven days a week with additional assistance from the care partners in each unit as

<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>required. A wide range of activities, addressing the abilities and needs of residents in the hospital and rest home, are offered. Activities include physical, mental, spiritual, and social aspects of life to improve and maintain residents' wellbeing. A programmed timetable was available for each care level, along with additional material promoting specific activities to encourage residents to join in.</p> <p>On admission the diversional therapist completes an assessment for each resident and an activity plan is completed. A record is kept of individual resident's activities and progress notes completed monthly. Reviews are conducted six-monthly (or earlier should the residents condition determine) as part of the care plan evaluation/review. The resident/family/EPOA as appropriate is involved in the development of the activity plan.</p> <p>Residents and family interviews confirmed they enjoyed the variety of activities and were satisfied with the activities programme. Activities included outings as well as community involvement. Some of those included in activities offered are church groups, trips to local restaurants, pet therapy, musicians, yoga, and Tai Chi. There are volunteers that assist with a variety of activities including van outings.</p> <p>Residents and families interviewed confirmed the activity programme was developed around the interest of the residents. A forum is held monthly where residents and relatives have input. Minutes are recorded at the forum, quality improvements identified, and feedback given.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The resident files reviewed showed long-term care plans had six monthly reviews completed and were updated when needs changed. Clinical reviews were documented in the multidisciplinary review (MDR) records, which included input from the GP, RNs, activities staff, physiotherapist, and resident/family. Progress notes were completed and reflected appropriate responses to interventions and treatments. Changes to care were documented. Documentation of GP visits evidenced that reviews were occurring at least three-monthly. Short-term care plans were in use for short-term issues.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The facility is split in to six households of twelve residents plus an eighteen-bed secure dementia unit. All care beds (dementia excluded) are dual purpose. There are multiple lifts, and stairs access between the levels and secure entrance and exits to the dementia unit.</p> <p>The building has a current building warrant of fitness that expires 20 August 2021.</p> <p>The facility employs a full-time maintenance officer, gardens, and grounds staff. Daily maintenance requests are addressed, and a 12-monthly planned maintenance schedule is in place and has been signed off monthly (sighted). Essential contractors are available 24 hours. Electrical testing is completed annually. An external contractor completes annual calibration and functional checks of medical equipment. This is next due July 2021. Hot water temperatures in resident areas are monitored. Temperature recordings reviewed were between 43-45</p>



		<p>degrees Celsius.</p> <p>The facility has wide corridors with sufficient space for residents to mobilise safely using mobility aids.</p> <p>Residents were observed safely accessing the outdoor gardens and courtyards. Seating and shade are provided. The caregivers and RNs interviewed stated they have sufficient equipment to safely deliver cares as outlined in the resident care plans.</p> <p>The dementia care unit has an open plan dining/lounge area. There is free and safe access to the outdoor area with raised gardens, seating, and shade.</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>	FA	<p>Infection surveillance is an integral part of the infection control programme and is described in Selwyn's infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow-up, review and resolution. Short-term care plans are used.</p> <p>Surveillance of all infections is entered on to a monthly infection summary. This data is monitored and evaluated monthly and annually and provided to Selwyn head office for benchmarking. Infections are part of the key performance indicators. Outcomes and actions are discussed at quality/staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible. There have been no outbreaks since the previous audit. Hand sanitisers are appropriately placed throughout the facility. Visitors are asked not to visit if they are unwell. Residents are offered the influenza vaccine.</p> <p>Covid-19 education has been provided for all staff, including hand hygiene, donning, doffing and use of PPE. During the lockdown period, more frequent head of department meetings were instigated, and stocks of PPE increased as an emergency preparation measure in addition to the maintenance of regular stock levels.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The restraint minimisation policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.2. The policy includes comprehensive restraint procedures. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. The restraint standards are being implemented and implementation is reviewed through internal audits, facility meetings, and restraint meetings at an organisational level. Interviews with the staff confirmed their understanding of restraints and enablers.</p> <p>Enablers are assessed as required for maintaining safety and independence and would be used voluntarily by the residents. On the day of audit, the service was not using restraint or enablers.</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 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA</p> <p>Moderate</p>	<p>Thirteen of the 24 incident reports reviewed were for unwitnessed falls or where the resident had hit their head. Of these, nine showed that neurological observations were completed as per policy. The shortfall identified at the previous audit remains.</p>	<p>Four of the incident forms for a resident who had an unwitnessed fall did not have neurological observations completed as per policy with one of these having been suspected of hitting their head.</p>	<p>Complete neurological observations as per policy for a resident who has had an unwitnessed fall or if they are suspected of hitting their head.</p> <p>60 days</p>

## Specific results for criterion where a continuous improvement has been recorded

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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
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End of the report.