

Metlifecare Limited - Selwyn Heights Retirement 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 Heights Retirement Village

Services audited: Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

Dates of audit: Start date: 7 December 2021 End date: 8 December 2021

Proposed changes to current services (if any): The bed numbers have reduced by three (to a total of 47) from that noted in the last audit report. The bed numbers detailed in the last audit report are reported by the clinical manager as being incorrect.

Total beds occupied across all premises included in the audit on the first day of the audit: 36



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 Heights, located in Hillsborough, Auckland. Takeover is anticipated to occur in late February 2022 subsequent to obtaining approval from three regulatory bodies: the Ministry of Health (MOH); the Retirement Village Statutory Supervisor; and the Overseas Investment Office.

Selwyn Heights provides rest home and hospital level care under agreement with their district health board (DHB) for up to a maximum of 47 residents. This is a reduction of three beds from that noted in March 2021.

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.

Metlifecare is a New Zealand company established in 1984 which owns and operates a large portfolio of retirement villages and care homes in the North Island. The company is experienced in delivering aged care services through its ownership of 11 care homes and is purchasing six care facilities from Selwyn Care. Interview with the clinical nurse director provided evidence of knowledge and understanding of the aged care sector and their preparedness to own and operate these additional facilities. Outcomes from the Metlifecare interview, review of the transition plans and the site visits conducted prior to sale and other due diligence activities, did not identify any areas of concern that potentially impacted on each facilities ability to meet HDSS requirements, or other legislative or regulatory compliance matters.

This audit process included a pre audit review of the current and 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 residents and family interviewed 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 March 2021.

There were no corrective actions requiring follow-up from the March 2021 audit. This provisional audit revealed there were no areas that did not comply with these standards.

Consumer rights

Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Services are provided that support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There was no evidence of abuse, neglect or discrimination.

The service has linkages with a range of specialist health care providers to support best practice and meet resident's needs.

A complaints management process is clearly described in policy. Residents and relatives are advised about the processes for raising concerns or complaints and are given written information about their right to complain and where to access independent support and advocacy if required. There have been no complaints received since the last audit.

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 care to older people under NZ legislation, these standards and funding agreements. They plan 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 care manager is on site five days a week and is supported by a senior registered nurse. There is always at least one other registered nurse (RN) on site to oversee the clinical care of residents.

Selwyn Care Limited have 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 available to staff.

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 and contractual requirements.

Residents' records are integrated and maintained in a secure manner. Entries in records meet best practice standards for the management of health records.

Continuum of service delivery

Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

The planned activity programme provides activities that are appropriate to the needs, age and culture of the residents. Activities are provided either in a group setting or on a one on one basis. Residents and family/whanau interviewed confirmed their satisfaction with the programme implemented. Activities during the pandemic have been more flexible to meet the needs of the residents, but no outings have occurred into the community.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals. The menu has been reviewed by a registered dietitian as meeting nutritional guidelines for older people. The service has a current food safety plan.

Safe and appropriate environment

Waste and hazardous substances are managed safely. Staff have access to protective equipment and clothing and were observed using this appropriately. There were sufficient supplies available. Chemicals are safely stored, and staff provided with training on chemical safety.

The building had a current building warrant of fitness and meets the needs of residents. Electrical equipment is tested. External areas are accessible, safe and provided shade and seating for residents. All areas of the home were well maintained and cleaned to an appropriate standard. Most laundry is currently managed offsite at another Selwyn facility. The personal laundry for residents living in the rest home is washed on site.

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. There are appropriate security systems in place.

Communal and individual spaces are well ventilated and maintained at a comfortable temperature.

Restraint minimisation and safe practice

The organisation has implemented policies and procedures that support the minimisation of restraint and align with the requirements of these standards. There were no residents using restraint or enablers on the days of audit. Staff have been actively working in 2021 to develop and maintain a restraint free environment. Use of enablers is voluntary for the safety of residents. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes and are provided with appropriate training.

Infection prevention and control

The infection prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education. Pandemic plans are adhered to and reviewed regularly as needed.

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

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	45	0	0	0	0	0
Criteria	0	93	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Selwyn Foundation has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Selwyn Heights has implemented these policies, procedures and processes. 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. The Code of Rights and informed consent training was provided in January 2021, and this incorporated a quiz on the topic. Further training was provided in May 2021 which included a presentation on the Nationwide Health and Disability Advocacy Service.</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</p>	FA	<p>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed showed that informed consent</p>

<p>informed choices and give informed consent.</p>		<p>has been gained appropriately using the organisation's standard consent form. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent was defined and documented, as relevant, in the residents' records. Staff were observed to gain consent for day to day care.</p>
<p>Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. The resident chaplain was always available for residents and families to talk to and to share any concerns.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. However, this has not been able to be implemented during the pandemic. The staff and the diversional therapist have introduced 'zoom', 'skype' and other means of communication to ensure family nationally and internationally were able to maintain contact with their individual family members.</p> <p>The facility has restricted visiting hours and encourages visits from residents' family/representatives, currently by appointment, to meet the legislative requirements during this global pandemic. Family members interviewed stated they felt grateful and welcomed when they visited and comfortable in their dealings with staff.</p>
<p>Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The complaints/concerns/issues 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. 'Help us help you' forms are readily available to residents to raise concerns, complaints or provide other</p>

		<p>feedback / compliments.</p> <p>The complaints register reviewed showed that there have been no complaints received since the last audit including complaints from the Ministry of Health (MOH), Health and Disability Commissioner (H&DC) and District Health Board (DHB). The care manager described the required process for investigating and responding to any complaints and the required time frames. All staff interviewed confirmed a sound understanding of the complaint process and their responsibilities in the event of a complaint being received.</p> <p>Prospective provider: The prospective provider has a well-established complaints management processes and these will be incorporated into their systems for monitoring and reporting.</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 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 the primary registered nurse. The Code is displayed in all service areas together with information on advocacy services, how to make a complaint and feedback forms. The staff interviewed had a good understanding of the Code and the Nationwide Health and Disability Advocacy Services available for residents to access if and when needed.</p> <p>Prospective provider: The prospective purchaser, demonstrated an understanding and knowledge regarding the Code. This was confirmed by the policy review and discussion about the organisational systems and how these are implemented in the 11 other care homes already operated by Metlifecare Limited.</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>The privacy policy is comprehensive, current and up to date with all legislative requirements being documented to guide staff. Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff were observed to maintain privacy throughout the audit. Training was provided to staff on 'Aging and Intimacy' (October 2021) with 29</p>

		<p>staff participating. In addition to this, training was provided on abuse and neglect and staff interviewed were fully informed on how to report any such incidents to management. Most residents have their own individual room. There is one room with two residents. The care manager has processes in place to ensure the sharing of this room is facilitated safely. The rooms were personalised with residents being able to have their own photographs, art work and belongings available to them.</p> <p>Residents are encouraged to maintain their independence by maintaining their interests and hobbies. Care plans included documentation related to the resident's abilities, and strategies to maximise independence. External outings and activities into the community during the nationwide pandemic have not been able to be undertaken so the focus has been on providing individual one on one and small group activities within the home.</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. The resident chaplain, present on the day of the audit, was available to all residents/families and staff. There is a chapel available but this is not accessible during the pandemic lockdown period. The chaplain was able to offer communion to residents on a one to one basis.</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>Staff support residents in the service 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. There is a current Māori health plan developed with input from cultural advisers. The staff can access the senior manager for the Selwyn Foundation people and culture team for guidance on tikanga best practice, and this is supported by staff who identify as Māori in the facility. There was one Māori resident and the whānau interviewed reported that staff acknowledged and respected their individual cultural needs. One staff member identified as Māori.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's</p>	<p>FA</p>	<p>Residents verified that they were consulted on their individual culture,</p>

<p>Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>values and beliefs and that staff respected these. Residents' personal preferences, required interventions and special needs were included in care plans reviewed. The organisation has adopted tikanga best practice and central to the policy sighted there is an expectation that all residents of the service are treated with dignity, respect and that all cultural needs and expectations are able to be effectively met. The resident satisfaction survey completed last in 2019, confirmed that individual needs are being met.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff employed at Selwyn Heights includes education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses have records of completion of the required training on professional boundaries. Staff are guided by policies, procedures and a flow chart and at interview demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<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, diabetes nurse specialist, wound care specialist, psycho-geriatrician and mental health services for older persons, and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for on-line forums both within the Selwyn Foundation and external online education and access their own professional networks to support contemporary good practice. Management and staff are well supported by the Selwyn Foundation Clinical Governance Group.</p> <p>Other examples of good practice observed during the audit included excellent staff morale, with the large core of staff, who when interviewed,</p>

		<p>described being fully committed to residential care and had provided significant input to maintaining the ongoing care and management of each resident during the pandemic.</p> <p>The activities programme has a strong focus on keeping all residents in contact with their families during the pandemic, and families interviewed spoke highly of the staff and the efforts taken to ensure this occurred.</p>
<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/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. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff know how to access interpreter services, although reported this was rarely required due to staff able to provide interpretation as and when needed and the use of family members by phone contact as needed. Interpreter services are also available through the Auckland District Health Board and/or through the Selwyn Foundation.</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 Heights business plan (July 2021 to June 2022). Annual business goals are linked to the strategic plan and reflected regular reviews.</p> <p>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. Another document monitors and reports on clinical indicator trends and any variations on a monthly basis.</p> <p>Selwyn Heights has a maximum occupancy for 47 residents. Eleven beds are certified for rest home level of care and are located on the upper level, and 36 beds on the ground level for the provision of hospital level care. On the days of audit there were 36 residents receiving care.</p>

		<p>Nine were receiving rest home level care and 26 receiving hospital care services under the age related residential care (ARRC) agreement with Auckland District Health Board. There was one other resident receiving care under the interim care contract at hospital level care. A secure dementia unit is being built on site. This service was not included in the scope of this audit. The care manager is anticipating the secure dementia service will be ready for a provisional audit sometime in January 2022.</p> <p>The service is managed by a care manager (CM) who is an experienced RN and has been in this role (or similar role/title) at the Selwyn Foundation since 2005. Responsibilities and accountabilities are defined in their job description and individual employment agreement. The CM confirmed knowledge of the sector, regulatory and reporting requirements. The care manager has maintained at least eight hours of professional development education related to managing an aged care facility and is supported by a senior registered nurse who has been in a permanent or acting role since 2015.</p> <p>There is a 'Selwyn Heights Herald' that is published regularly to help keep residents and family members informed. The most recent edition (December 2021) included information on The Selwyn Foundation's outcome from the organisation's strategic review including the intention to sell Selwyn Heights and a number of other care homes and villages. This information had also been communicated to staff, residents and family members via other forums.</p> <p>Prospective provider: 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</p>
--	--	--

		<p>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> <p>Staff, residents and family members have also been informed of the prospective sale of the care home.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>The Selwyn Care homes have established systems for covering senior staff and management absences. When the CM is absent, the senior registered nurse is responsible for services with the support of the clinical quality manager (CQM) and the Selwyn Heights village manager and deputy. The senior RN can detail the responsibilities and confirmed appropriate supports have been available when covering in the care managers absence.</p> <p>Prospective provider: 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>	FA	<p>Selwyn Care has a quality and risk management plan which is aligned to their strategic and business plans. This clearly describes the systems for service monitoring, review and quality improvement. Service goals are documented in the facility's annual business plan which is monitored for progress by senior management.</p>

		<p>Interview with the quality clinical manager confirmed the service policies are reviewed at a national level every one to three years with more frequent reviews if changes are required. Changes in policy, or the development of new policies or procedures are communicated to the care manager. The care manager is subsequently responsible for ensuring staff are informed. Current policies and procedures are accessible to staff electronically. One of each of the quality manuals is available in paper version on site. The administrator is responsible for document control processes at Selwyn Heights.</p> <p>Review of the documented outcomes from internal audits and incidents reported since the previous recertification audit in March 2021 confirmed the quality and risk system as effective and compliant with this standard. Discussions with the CM and staff confirmed their involvement in quality and risk management processes. The system monitors and reports on all aspects of service delivery. This includes collecting and analysing a range of quality data, such as resident falls, infections, pressure injuries, medication errors, restraint use, incidents, and skin tears. This data is benchmarked monthly against other Selwyn Care facilities, and externally with other large providers of aged care as clinical key performance indicators (KPI's). Results are utilised for service improvements. Compliments are also recorded and communicated to staff.</p> <p>Internal audits are conducted according to an annual internal audit schedule and using template audit forms. The results of completed audits indicates a high degree of compliance with the organisation's requirements. Staff are kept informed via meetings and during handovers of relevant quality and risk issues.</p> <p>Staff document corrective actions for any service shortfalls identified through internal audits, incidents, staff meetings, hazard identification or feedback from residents or relatives. Evidence of corrective actions being implemented was confirmed by interviews and information contained in the records of internal audits, incident forms sampled and staff meeting minutes. The minutes of at least four 'combined staff' meetings were reviewed. All staff employed are invited to these meetings.</p> <p>Resident meetings occur monthly (where able within the National Covid-19 alert level settings). Minutes from these meetings confirmed that</p>
--	--	--

	<p>residents are consulted about service delivery and are kept informed. Resident and relative satisfaction is formally surveyed. The last survey was conducted by a third party organisation in 2019. The survey for 2020 and 2021 did not proceed due to Covid-19 alert level precautions. The care manager has an open-door policy and walks throughout the care home interacting with residents and speaking with them one-on-one. The residents and family members interviewed confirmed they were kept informed and consulted about services, and the impact of Covid-19 alert levels restrictions on day-to-day care home activities and visiting.</p> <p>The service understands the requirements of the Health and Safety at Work Act 2015 including notifying staff when changes in practice or policies have occurred. Selwyn Heights has a nominated staff health and safety representative, who has completed relevant training for the role. The H&S representative was able to detail the position responsibilities which are also detailed in a signed job description. External contractors and new staff undergo health and safety orientation. Quality and risk topics and health and safety is included in the ongoing education programme.</p> <p>The hazard registers are displayed in applicable locations. The hazard registers sighted were dated 2016 and are reported to be only reprinted and replaced if there is a change in the content. There is an electronic hazard register that details more regular and recent review.</p> <p>Prospective provider: Metlifecare have access to the Selwyn Care group's policies and procedures and these are currently being reviewed and compared with the Metlifecare policy set to determine areas of excellence, where policies are the same or where these can be merged. The intention is to gradually introduce all staff to the reviewed Metlifecare policies over the first six months of ownership. A pre audit review of Metlifecare policies confirmed that the existing policy set meets the requirements of the current standards, all known legislative, contractual and regulatory requirements.</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.</p> <p>Progress with meeting quality indicators is reviewed by the</p>
--	--

		<p>organisational clinical governance group and the executive management team.</p> <p>Site specific quality data, such as reportable events, infections, complaints and resident/relative feedback is collected and analysed before being, presented at local quality and risk team meetings, clinical management team meetings and full staff meetings. Each care facility conducts regular internal audits. Monthly summaries of quality data is benchmarked against other Metlifecare sites. The organisation also compares its overall quality data with five other New Zealand age care providers, one of which is Selwyn Care.</p> <p>This sharing of performance information between Selwyn Care and Metlifecare senior executive team members conducting site visits prior to the signing of the sales and purchase agreement, confirmed that the purchaser is fully informed about the positive and potential growth areas for each site.</p> <p>Infection control data is benchmarked by a contracted off-site provider.</p> <p>Metlifecare has documented transition plans that include communication strategies about the change of ownership to all involved parties and allocated responsibilities to key personnel for identifying and managing areas of concern or gaps that require immediate attention.</p> <p>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 except for resident related events which are documented directly in electronic resident management system in use. A sample of at least seven incident forms verified appropriate events were reported, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse events are provided a severity assessment code (SAC) rating. Events noted as critical events had detailed investigation, action planning, and debrief. These events were discussed with the CQM, who assists with follow-up.</p> <p>Staff are required to document all communication with the resident and family (open disclosure) and with the GP where this occurs. Open</p>

		<p>disclosure is documented as occurring for applicable sampled events and the GP informed in a timely manner where clinically indicated. Post neurological monitoring has occurred post unwitnessed resident falls according to policy for applicable sampled events.</p> <p>The CM and senior RN can review data of reported events per resident, or for a designated time period, or per category / type of event. Adverse event data is collated, analysed and electronic reports are generated monthly. These reveal clear descriptions of each event, and another report graphs all events to reveal any trends over a 12 month period. The CM documents a narrative of any variations monthly.</p> <p>The CM and the clinical quality manager described essential notification reporting requirements and detailed the type of events that are required to be reported. The CM and CSM advised there have been four notifications to the Ministry of Health since March 2021. These related to the unplanned loss of power, and an activated smoke alarm (April 2021), a resident admitted with a stage three pressure injury (June 2021), and an absconding resident whose absence was reported to the Police (September 2021). No other police investigations, coroner's inquests, issues based audits or other notifications to regulatory bodies have occurred since the last audit.</p> <p>Prospective provider: Metlifecare have well established systems for reporting and recording adverse events. Interview with the clinical nurse director and review of company documents confirmed the purchaser understands their responsibilities for preventing, managing and reporting notifiable events to 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>Selwyn Care staff management procedures 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. The CM is assisted by designated staff from support office with recruitment related activities. A sample of staff records reviewed confirmed the organisation's policies are being implemented and records are maintained.</p> <p>There is a formalised orientation specific/relevant to each role. Staff are buddied with a senior staff member for a designated number of shifts.</p>

	<p>Staff reported that the orientation process included emergency preparedness and the facility/equipment, preparing them appropriately for their role. Staff records reviewed showed documentation of completed orientation and review/discussion within 90 days of commencing employment. Annual performance appraisals are occurring for clinical / care staff. The CM has a list that details when appraisals are due and completed. This information aligned with appraisal records in sampled staff files. Two out of two non-clinical staff that report to the village management team are overdue annual appraisals. This is not raised as an area for improvement as clinical and care staff appraisals are current.</p> <p>Continuing education is planned and includes mandatory training requirements according to the 'Selwyn Learning' schedule. The training programme includes components required to meet ARRC contract requirements and to meet these standards and notes the frequency each topic is to be completed. There is an online theory component and an associated questionnaire that staff are required to complete. Staff are required to obtain 100% in the questionnaire and may have up to three attempts per module. Staff are advised to seek assistance from the CM or senior RN before attempting a questionnaire for the third time facilitating staff knowledge to be reviewed and education / assistance provided where required. There are also annual practical competency assessments for medication management, hand hygiene, donning and doffing personal protective equipment (PPE), and manual handling/use of the hoist. The senior register nurse has a file box containing the completed competency assessments for 2021. Staff are required to complete the medicine competency assessment programme (if relevant to their role), before administering any medications.</p> <p>The CM advised care staff have a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. Of the 25 carers employed, 17 have achieved level 4 of the national certificate in health and wellbeing (or equivalency), and two are at level three. Five of the six carers and one of the cleaners interviewed have been at Selwyn Heights (or the previous facility owner) for between 15-30 years.</p> <p>Six registered nurses employed are maintaining their annual competency requirements to undertake interRAI assessments.</p>
--	--

		<p>Prospective provider: The prospective provider demonstrated knowledge and understanding about NZ employment legislation. Metlifecare will introduce their human resources management systems for recruitment, performance management, and professional development and payroll services after takeover. All existing staff will be offered an employment agreement. Additionally, an 'Integration Team' is being set up to assist Selwyn Care staff to transition to the 'Metlife way'. It was stated that there will be a focus on clinical services and reinforcing clinical governance.</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). Selwyn Heights adjusts staffing levels to meet the changing needs of residents. The CM reports on staffing hours utilised to the chief operating officer (COO) weekly. A management afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family members interviewed supported this.</p> <p>Staff work set shifts and days on the roster. However, may assist in covering other shifts for unplanned and planned staff leave. The Selwyn Foundation has an internal bureau with staff available for different roles for planned and unplanned absences. With the current Covid-19 precautions in place, designated Selwyn bureau staff are working at Selwyn Heights only, in order to minimise risks associated with staff who would normally be moving between several Selwyn Foundation care facilities. Observations and review of a two weekly roster confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence with rare exception.</p> <p>In addition to the care manager and senior RN, there are two RNs rostered on each morning shift, two RNs in the afternoon (one works a part shift), and one RN at night. Six carers are rostered for each morning shift (with two working a part shift), five carers in the afternoon (with two working a part shift) and three carers at night. There is a minimum of three carers and a RN on duty. Applicable RNs are allocated one day a month as a designated office day to complete InterRAI assessments /</p>

		<p>care planning requirements.</p> <p>Two cleaners are on the care home roster covering at least eight hours a day (usually more) including the weekend. Activities staff (one diversional therapist and an activities assistant) are employed for sufficient hours with at least one on site seven days a week. The administrator works weekdays eight hours a day.</p> <p>Three staff are in the maintenance team providing services to the care home and village. Gardening is undertaken by a contracted company. Most laundry services are provided by the Selwyn Laundry (off site). Care staff working in the rest home area undertake laundry services for the rest home residents. Catering services are provided for the care home and village by a contracted catering company.</p> <p>At least one staff member on duty has a current first aid certificate and current medicine competency, as verified by records sighted.</p> <p>There are two general practitioners and one nurse practitioner providing services. A GP currently comes on site on Monday's and another GP provides services via telehealth on Thursdays and are available on call after hours. Contracted allied health staff have not been on site since the Covid-19 restrictions were implemented in August 2021.</p> <p>Prospective provider: The integration plan describes no expected changes to the current configuration of staff at Selwyn Heights. The interviewee stated there was an existing alignment of policy and practices for staff hours and skill mix between the two organisations.</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>All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with the general practitioner and allied health service provider notes. Allied health professionals have not been able to visit residents on site during the pandemic, but the physiotherapist was able to provide instructions for any resident electronically and the physiotherapist aid was able to implement the instructions to ensure this was provided to meet the needs of the residents. Dietitian input was able to be sought and residents' records evidenced this had occurred.</p> <p>Records included the interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable. The service has introduced an electronic resident information system but still maintains hard copy records. Back-up systems are available for the electronic system. Archived hard copy records are stored securely in a locked room and are able to be retrieved if and when they are required. Records are held for the required legislative timeframe before being destroyed. No personal or private resident information was on public display during the audit.</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>	<p>FA</p>	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The organisation seeks updated information for residents accessing respite care.</p> <p>Family members interviewed in person and by telephone 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. Service charges comply with contractual requirements.</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>	<p>FA</p>	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB's 'yellow envelope' system to facilitate transfer of residents to and from acute care services. Stickers are also used on the yellow bag to verify COVID screening verification and PCR test results. A summary care plan is printed off the electronic system to highlight care management information, the resident's GP and any other relevant information. The health management form provides medical past history, diagnoses, past health status and other relevant medical related issues. There is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident including any alerts. All referrals are documented in the progress notes. An example was reviewed of a resident who recently transferred to the ADHB acutely and transferred back to the facility after treatment.</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. Photographic identification on each medication record reviewed was current. All intolerances and allergies/sensitivities were recorded on the medication records and the clinical records reviewed.</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 were competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input was provided six monthly and at any time required.</p>

		<p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six monthly stock checks and accurate entries were documented in red ink. Emergency medications are checked monthly.</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 include the prescriber's name and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines are met. The GP and RNs monitor the use of PRN (as required) medicines. The required three monthly GP review was consistently recorded on the electronic medicine chart.</p> <p>There were no residents who were self-administering medications at the time of audit. Appropriate processes were in place to ensure this is managed in a safe manner if and when required.</p> <p>There is an implemented process for reporting and comprehensive analysis of any medication errors.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service is provided on site by an external contractor/qualified chef and kitchen team 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 within the last two years. Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued on behalf of the Ministry for Primary Industries (MPI); the food control plan expires 07 April 2022. A recent verification report was reviewed, and no non-conformances were identified. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The food services site manager is a qualified chef and has undertaken a safe food handling qualification, with other chefs and kitchen assistants completing relevant food handling</p>

		<p>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>Evidence of resident satisfaction with meals was verified by resident and family interviews, resident meeting minutes and in satisfaction surveys – when occurring. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>If a referral is received but the prospective resident does not meet the entry criteria or there is currently 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. 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>Information is documented using validated nursing assessment tools, such as a pain scale, falls risk, skin integrity, nutritional screening and depression scale, as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed by one of the six trained interRAI assessors on site. Residents and families confirmed their involvement in the assessment process.</p>
<p>Standard 1.3.5: Planning</p>	FA	<p>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant</p>

<p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>		<p>clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed. Selwyn Heights is transitioning to electronic records. Both hard copy and electronic records are currently fully maintained and were accessible at the time of the audit.</p> <p>Care plans evidenced service integration with progress notes, diversional therapist - activities notes, medical and allied health professionals' notations clearly written, informative and relevant. During the pandemic, some allied health staff have been unable to visit residents' onsite (e.g., the podiatrist, hairdresser and physiotherapist), however, telephone and email correspondence evidences there is some involvement as requested. The physiotherapist can make a plan and the physiotherapist assistant (an experienced caregiver) is able to carry out the instructions provided for an individual resident. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans. Staff handover, both written and verbal between the shifts, was observed.</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 provided to 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 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>FA</p>	<p>The activities programme is provided by one trained diversional therapist holding the National Certificate in Diversional Therapy Level 4, care staff as able, and rostered volunteers.</p> <p>A social assessment and history are undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an</p>

		<p>activities programme that is meaningful to the residents. The resident's activity needs are evaluated six monthly and as part of the formal six monthly care plan review.</p> <p>Activities reflected residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings and satisfaction surveys (when these have been undertaken). Minutes of meetings were reviewed. Residents interviewed confirmed they find the programme meaningful and entertaining. However, with the current pandemic no outings to the community have been permitted. Small group activities and one on one activities have been implemented and encouraged over this time in each service area.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Residents' care is evaluated on each shift and reported in the progress notes. 'Stop and Watch' early warning tool is used and encouraged on all shifts when care staff observe or identify any change/decline in a resident's condition. 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. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for infections, wounds, post falls and for periods of confusion. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes. Families confirmed that when there was any change in their family member's health status, they were informed immediately by the RNs.</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</p>	FA	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a contracted GP in a practice of three GPs and a nurse practitioner (NP), residents may</p>

<p>disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>		<p>choose to use another medical practitioner. If the need for other non-urgent services is indicated or requested, the GP/NP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to the orthopaedic clinic and other DHB services. The resident and the family/whānau 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 or to the ADHB services as arranged. Processes are in place should a resident be transferred back to Selwyn Heights in respect of COVID-19 risk management.</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 storage and management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. An external company provides chemicals and cleaning products, and they also provide relevant training for staff. Training on waste management and hazardous substances is included in the ongoing education programme with all except three staff completing requirements in June 2020. Management of cytotoxic waste was discussed in the November 2021 staff meeting.</p> <p>Material safety data sheets (MSDS) were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur. Posters provide a summary about the safe use of chemicals on site. A fully equipped spill kit was sighted.</p> <p>There are appropriate supplies of personal protective equipment (PPE), and staff and visitors were observed to be using these.</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>A current building warrant of fitness (expiry date 30 September 2022) is publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. There is a maintenance schedule, with some aspects/components initiated by staff in support office on a scheduled basis. The testing and tagging of electrical equipment was current in sampled equipment (dated January</p>

		<p>and April 2021) and calibration of bio medical equipment was current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. Visual inspection revealed the environment was hazard free, and that residents are safe and independence is promoted.</p> <p>Hot water is tested on a monthly basis and is within the required temperature in sampled areas.</p> <p>There are two facility vehicles that have current registration and warrant of fitness. The vehicle hoist is reported to have been serviced by an approved contractor within the last 12 months.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting. There are at least three areas residents and family can use, with furniture and shade.</p> <p>Residents confirmed they know the processes they should follow if any repairs or maintenance is required, and that maintenance requests are addressed in a timely manner, and this was verified by staff.</p> <p>Prospective provider: 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>	<p>FA</p>	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. Three bedrooms in the rest home have their own toilet. The other rooms share a toilet between two or four rooms. There are two accessible showers for resident use. In the hospital area, one bedroom has its own toilet. The other bedrooms have one toilet shared between two residents' bedrooms. There are sufficient accessible showers for resident use in the hospital area. The hospital is made up of three wards.</p> <p>Appropriately secured and approved grab rails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence. There are privacy signs and locks</p>

		present.
<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.</p> <p>All bedrooms are large enough to accommodate lifting equipment and staff to assist residents if required. All bedrooms are for a single occupant except for one room in the hospital wing that is used by two residents. There are privacy curtains between each bed area and space for reach resident. Other rooms that had call bells and space for two residents are now only used for one resident with 47 beds available for use according to the care manager.</p> <p>Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>There is room to store mobility aids/hoists, wheelchairs and mobility scooters. Staff and residents interviewed confirmed there is more than sufficient space available in the residents' rooms for the resident, the facility and residents' personal furnishings and staff assistance.</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>A range of communal areas are available for residents to engage in activities on both floors. There is an open plan dining and living room on each floor. There is a library lounge area in the rest home and a library/activities area on the hospital floor. Some residents' rooms have their own lounge area within their room.</p> <p>All dining and lounge areas are spacious and easily accessible for residents and staff. Residents can access other areas for meetings with family and privacy, as and if required. Furniture 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</p>	FA	<p>Laundry services are provided at the Selwyn laundry facility in Auckland for the facility laundry and the personal clothes of hospital level care residents. Staff receive, fold/iron and return clean laundry to the residents. There are laundry facilities (a washing machine, dryer and a</p>

<p>is being provided.</p>		<p>drying rack) in the rest home wing where staff process and return the personal clothes of rest home residents. The residents interviewed were satisfied their laundry is washed and returned in a timely manner. Care staff demonstrated a sound knowledge of the processes for handling clean and soiled linen.</p> <p>Each of the designated cleaners have attended education on the safe handling of chemicals. Bulk chemicals were stored in a lockable cupboard. Cleaners decant these into appropriately labelled containers with assistance of auto dispensers. Cleaning trolleys are securely stored when not in use, as observed and verified with the two cleaners interviewed. There has been an increase in spot cleaning of high touch surfaces as part of the Covid-19 prevention activities.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme and through resident and family feedback. No concerns were raised about the services provided during resident and family interviews.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems 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 in poster form and known to staff.</p> <p>Disaster and civil defence planning guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. The service has an approved New Zealand Fire Service (NZFS) evacuation scheme dated 20 January 2004. Fire evacuation training and drills are conducted six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 12 April 2021. The October 2021 fire drill could not occur due to Covid lockdowns restrictions. However, the care manager is liaising with the fire safety contractor to reschedule this now that visitors can come on site. Email communications in regard to this was sighted. The staff orientation programme includes fire, security and emergency response training. Staff confirmed their awareness of the emergency procedures.</p> <p>There are security cameras on site monitoring communal areas and some external areas. External signage alerts that cameras are in use. There are processes in place for the care manager to access images</p>

		<p>with appropriate prior organisation approval.</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 47 residents. This meets the Ministry of Civil Defence and Emergency Management recommendations for the region. These supplies are checked at least six monthly (via a checklist) or sooner if used. The maintenance supervisor notes there is 4,000 litres of water available in emergencies for the care home. Additional water supply is available for the village.</p> <p>There is a portable generator available on site. This is tested monthly. Emergency lighting is regularly tested. The uninterrupted batteries (UPS) have been replaced for the hospital and chapel areas. Replacement of the UPS for the rest home is due.</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.</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>	FA	<p>All resident areas are provided with plenty of natural light and good ventilation. There is centralised heating via wall panels. The temperature setting in summer is reported to be around 20 degrees Celsius. There is ceiling air conditioning in communal areas and corridors in the hospital. Portable air-conditioning units are being used in the corridor areas in the rest home. Residents and families interviewed confirmed the care home is normally maintained at a safe and 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>	FA	<p>The service implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, and advice from an infection control contracted service provider. The infection control programme and manual are reviewed annually. The review was last completed on the 21 November 2021.</p> <p>The care manager/registered nurse is the designated infection control</p>

		<p>coordinator (ICC), whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the clinical quality manager and tabled at the quality/risk committee meeting. A pandemic plan is developed for the Selwyn Foundation and all facilities have implemented the plan including Selwyn Heights. The plan reviewed is based on the New Zealand COVID-19 protection framework.</p> <p>Signage and entry screening occurs at the main entrance to the facility. Vaccine passports are part of that process with dates of last vaccination also being recorded. There is also a process for anyone who is not vaccinated to follow. 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 responsibilities.</p> <p>Any resident being admitted to the service or readmitted after a transfer to the DHB are fully screened on day one and day five and stay in isolation for seven days. Processes are closely monitored by the infection control coordinator (ICC). Families can visit on an appointment basis only and this was observed during the audit. Personal protective equipment (PPE) is readily available, and all staff were well informed about how to wear all items used for infection prevention and control.</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>	<p>FA</p>	<p>The ICC has appropriate skills, knowledge and qualifications for the role, and has been in this role since 2009. The ICC has undertaken infection prevention and control training and attended relevant study days, as verified in training records sighted. Two registered nurses also attended a one day workshop for registered nurses in aged care in May 2021 presented by the New Zealand Aged Care Association Education Trust and endorsed by the College of Nurses Aotearoa NZ. A forum is held annually for all ICCs for the Selwyn Foundation and education and any infection issues are discussed. Minutes of the forum were available to review.</p> <p>Additional support and information are accessed from the infection control team at the Auckland District Health Board (ADHB), the pathologist at the community laboratory, the general practitioner (GP) and public health unit, as required. The coordinator has access to</p>

		<p>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 infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed 19 November 2021 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. 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>Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified RNs, and the ICC. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. All staff received education 23 February 2021 and infection control is covered at the monthly staff meetings and education sessions. When an infection outbreak or an increase in infection incidence has occurred, there was evidence that additional staff education had been provided in response. An example of this occurred in both 2020 and 2021 during this nationwide pandemic which is still at large and currently being managed under the New Zealand COVID-19 protection framework (traffic light system).</p> <p>Education with residents is generally on a one-to-one basis. Staff have had regular contact with resident's families over this lockdown period. Families interviewed have appreciated this and spoke highly of the staff involved.</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 and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. The ICC reviews all reported infections, and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>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 regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the clinical quality manager. Data is benchmarked externally within the group and other aged care providers. Benchmarking has provided assurance that infection rates in the facility are below average for the sector.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Restraint minimisation policies and procedures are comprehensive and included definitions, processes and use of restraints and enablers and these align with the standards. The CM and senior RN confirmed restraint interventions are only used where clinically indicated and justified, and alternative strategies have been tried and were ineffective. The Selwyn Foundation has undertaken a quality initiative 'towards zero restraint'. The use of restraint and enablers is monitored via the internal audit programme. A registered nurse is the designated restraint coordinator at Selwyn Heights, and responsibilities of this role are documented in a signed position description. The staff at Selwyn Heights were recognised by The Selwyn Foundation in July 2021 for being a restraint free facility. The restraint coordinators from the various Selwyn Care facilities formally meet together at least annually.</p> <p>There were no resident's using restraint or enablers at the time of the audit.</p> <p>Staff training around restraint minimisation and use of enabler, falls prevention and management of challenging behaviours occurs during</p>

		orientation and as part of the ongoing education programme.
--	--	---

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.

No data to display

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.