

Metlifecare Limited - Selwyn Oaks

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 Oaks
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 10 December 2021 End date: 11 December 2021
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	43

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 Oaks, located in Papakura, 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 Oaks provides rest home and hospital level care under agreement with their district health board (DHB) for up to a maximum of 48 residents.

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 members 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 2019, with the exception of a new assistant care manager who was internally promoted in February 2020.

There were no corrective actions requiring follow-up from the March 2019 audit. This provisional audit revealed there are two areas that did not fully comply with these standards, related to corrective action planning and staff training.

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 provided 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. All complaints have been investigated and followed up in a timely manner.

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 and hospital level 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 village and care manager is on site five days a week and is supported by an assistant care manager. 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 and are available to staff.

The appointment, orientation and management of staff adheres to good employment practices. There is an implemented orientation programme, relevant to the new employee's role. Ongoing education is provided. 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. Records 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 stored securely. An electronic medicine management system is in use.

The food service has a validated food safety plan. Special diets cater for all residents and likes and dislikes are considered. Food allergies are recorded on the care plan and food service records. The menu is planned and reviewed every two years.

Safe and appropriate environment

The building is on three levels, with residents living in one of four households. Each household is for up to 12 residents, with each bedroom having a ceiling hoist installed and full ensuite bathroom. There is an open planned kitchen, dining and lounge area in each household. Other private spaces are available for residents and family members to use and for recreation activities.

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. Residents can do their own laundry on site if they want, with two laundry facilities available. Almost all the laundry is currently processed offsite at another Selwyn facility.

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.

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. The use of enablers is voluntary for the safety of residents. Staff and managers report restraint has not been used on site for at least five years. 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	43	0	0	2	0	0
Criteria	0	91	0	0	2	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>Policies reflect the Code of Health and Disability Services Consumer Rights (the Code). The Code is included in the orientation of all new staff and staff interviewed demonstrated knowledge of the Code. The Code is also discussed as part of the annual in-service education programme. Residents and relatives interviewed, and observation during the audit, indicated that staff understand residents' rights and their responsibilities and that rights are observed in practice.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>The consent policy and procedure references consumer right legislation, including competency/mental capacity. There is also a policy on advance directives. Nursing and care staff interviewed understood the principles and practice of informed consent. Clinical records sampled confirmed that informed consent has been gained appropriately using the organisation's standard consent forms. These are signed by residents, enduring power of attorney (EPOA), and the general practitioner makes a clinically based decision on resuscitation authorisation if required. Staff were observed to gain consent for daily cares. Interviews with family</p>

		members confirmed the service actively involves them in decisions that affect their family members' lives.
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	Residents are informed of their right to access independent advocacy services. Information is readily available. A representative from the Nationwide Advocacy Service visits the facility and provides staff training annually on advocacy issues. Residents and staff understood the resident's rights to have a support person of their choice. During COVID-19 staff kept in touch with the support persons or representatives for each resident on a regular basis.
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	Residents are assisted to maximise their potential for self-help and to maintain links with their family. During the lockdown periods it has been difficult to ensure residents are involved with the community, as all van outings were not able to take place and family were unable to visit. On the day of the audit processes are in place for arranged visits from family members by appointment and these are taking place in the lounge or outside areas as requested by the family and the resident. Family interviewed stated they were closely connected through this lockdown by staff with arranged zoom/skype/telephone meetings and were very grateful to the staff involved.
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<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 to help you' forms are readily available to residents to raise concerns, complaints or provide other feedback/compliments.</p> <p>The complaints register reviewed showed that there have been seven complaints received since January 2021. There have been no complaints received from the Ministry of Health (MOH) or District Health Board (DHB) since the last audit. One complaint was received via the Health and Disability Commissioner (HDC). This was responded to and was</p>

		<p>closed on 20 March 2020. There were no findings made against Selwyn Oaks.</p> <p>The village and 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. The clinical quality manager and The Selwyn Foundation director of risk assist with the review and response to significant complaints.</p> <p>Prospective provider: The prospective provider has a well-established complaints management process and this 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>Information about consumer rights legislation, advocacy services and the complaints process are provided on admission and displayed at reception. The Code is available in both te reo Māori and English versions. Family/whanau and residents interviewed were aware of consumers' rights and confirmed that information was provided to them during the admission process.</p> <p>The admission brochure outlines the services provided. Admission agreements signed earlier by the resident or by an enduring power of attorney (EPOA) were sighted in records sampled. Admission agreements meet the district health board (DHB) requirements.</p> <p>Prospective provider: The prospective provider is aware of and understands the consumer rights it must adhere to.</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>There is a policy and procedure regarding residents' safety, neglect and abuse prevention. This includes definitions, signs and symptoms and reporting requirements. There are policies regarding protection of vulnerable adults, sexuality and intimacy. These provide guidelines on respect, safety and privacy. Guidelines on spiritual care to residents are also documented. There is a resident chaplain and church available in the home. The privacy policy references current legislation. There were</p>

		<p>no documented incidents of abuse or neglect in the records sampled. The general practitioner (GP) reiterated that there was no evidence of any abuse or neglect reported. Family/whanau and residents interviewed expressed no concerns regarding abuse, neglect or culturally unsafe practice.</p> <p>Residents' privacy and dignity are respected. Staff were observed maintaining privacy. Residents are supported to maintain their independence with residents assessed as requiring rest home and hospital level care. Records sampled confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their individual care plan.</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>	FA	<p>The organisation has a comprehensive Māori health plan and tikanga best practice guidelines to guide staff safely. This references the Treaty of Waitangi and Ministry of Health (MOH) Māori Health Strategy. Training on cultural appropriateness is provided to all staff. There were two Māori residents and two staff employed who identify as Māori. The organisation endeavours to reduce barriers to access by ensuring a culturally appropriate environment and staff awareness. Staff interviewed confirmed that the services provided were in line with the needs of Māori and the local community. The Selwyn Foundation Service Manager People and Culture Team was contactable for any advice/guidance as required. Māori residents' whanau are encouraged to be involved with the residents' request. Any specific identified needs are clearly documented on the individualised care plans. A holistic approach to service delivery was observed when reviewing the care plans.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Cultural needs are determined on admission and a care plan is developed to ensure that care and services are delivered in a culturally and/or spiritually sensitive manner in accordance with protocols/guidelines as recognised by the family/whanau. Values and beliefs are discussed and incorporated into the care plan. Family members and residents interviewed confirmed they are encouraged to be involved in the development of residents' care plans. Residents'</p>

		personal preferences and special needs were included in the residents' care plans reviewed.
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and this was confirmed by the residents. The induction process for staff includes education related to professional boundaries, expected behaviours and the code of conduct. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation. The assistant care manager (ACM) stated that there have been no reported or alleged episodes of abuse/neglect or discrimination towards residents. This was confirmed by the general practitioner interviewed.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service providers demonstrated several areas which reflected good practice. These included the focus on staff education and ongoing professional development of staff providing numerous forums and educational sessions both online and at the monthly staff meetings and the holistic approach to service delivery and the enduring Christian commitment of the Selwyn Foundation that is clearly embedded within Selwyn Oaks. Staff are focused on the resident's overall wellbeing, not just their clinical care, with the allocation of dedicated care partners which enables familiarity with a person's individual needs so that holistic and healthy aging occurs.</p> <p>The two floors of the building are divided into four households with both rest home and hospital level residents combined. Each household has its own 24 hour care partners, own lounge/dining areas with an open kitchen area, front door and entrance bell. The concept works effectively and provides a homely environment.</p> <p>The organisation provides a professional study day annually for all infection control coordinators and restraint coordinator from all sites. This provides a forum for ongoing learning from each other and supports contemporary good practice. The general practitioner (GP) confirmed that the service sought prompt and appropriate medical intervention</p>

		when required and were responsive to medical requests. The GP cover for this facility has recently changed and the doctor interviewed specialises in gerontology and has the support of other GPs as needed.
<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>The open disclosure policy and procedure meets the requirements, including the key principles, responsibilities and an apology. There was evidence that family members were informed following events, or a change in the individual resident's health status. Residents and families stated that they receive sufficient and current information from the organisation as required. Communication with family members was maintained during COVID-19 lock down period with family members stating that they were kept well informed with phone calls and/or zoom/skype contact as well.</p> <p>All residents and staff can communicate in English. There is access to interpreting services if required through the DHB, staff and other organisations.</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 Oaks 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. The village and care manager (V&CM) also has monthly meetings with the chief operating officer (COO).</p> <p>Selwyn Oaks has a maximum occupancy for 48 residents and is utilising the new Selwyn model of care. The care home is made up of smaller 'house holds', with staff working as care partners. All beds are certified for the provision of rest home level and hospital level of care. On the days of audit there were 43 residents receiving care. Five were receiving rest home level care and 37 receiving hospital care services under the</p>

	<p>age related residential care (ARRC) agreement with Counties Manukau District Health Board (CMDHB). There was one other resident receiving care under the short-term care contract at rest home level care.</p> <p>The service is managed by a village and care manager (V&CM) who is an experienced RN and has been in this role (or similar role/title) at the Selwyn Foundation for over five years. Responsibilities and accountabilities are defined in their job description and individual employment agreement. The V&CM confirmed knowledge of the sector, regulatory and reporting requirements. The V&CM has exceeded eight hours of professional development education related to managing an aged care facility in the last 12 months, and is supported by an assistant care manager (ACM). The ACM is an experienced aged care registered nurse who has been in this role since February 2020.</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 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</p>
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		<p>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. Staff interviewed noted this process was done with representatives of both the current and prospective owners governance group on site (using appropriate personal protective protection), and via electronic methods for those staff not on site at the time.</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 V&CM is absent, the assistant care manager (ACM) is responsible for services with the support of the clinical quality manager (CQM). The ACM can detail the responsibilities and the activities that are not included 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>	PA Moderate	<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>The V&CM advised policies are reviewed at a national level on a scheduled basis. Any changes in policy, or the development of new policies or procedures are communicated via emails or at management meetings. Recent meetings included updates on the end of life choice legislation, new sector standards, pressure injury prevention policy, and goals of care documentation. The village and care manager is responsible for ensuring staff are informed of changes. Staff are required to read updated policies / procedures and sign that they understand the contents. Current policies and procedures are accessible to staff electronically. One of each of the quality manuals is available in paper</p>

		<p>version on site, with document control processes implemented.</p> <p>Review of the documented outcomes from a selection of internal audits and incidents reported in 2021 confirmed the quality and risk system is effective and compliant with this standard. Discussions with the V&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, any 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, and staff appreciated being informed.</p> <p>Internal audits are conducted according to an annual internal audit schedule and using template audit forms. The results of completed audits indicated a high degree of compliance with the organisation's requirements for sampled audits. Staff are kept informed via meetings and during handovers of relevant quality and risk issues. The minutes of recent 'combined staff' meetings and registered nurse meetings were sighted. The V&CM sends the minutes to all applicable staff electronically with a 'read receipt', as a way of monitoring that all staff are keeping up to date with current or key information. While there are examples of appropriate corrective action planning, this is not consistent and is an area requiring improvement.</p> <p>Resident meetings occur regularly, in each household. Minutes from these meetings confirmed that 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 management team have an open-door policy and were available to family members via phone and email when family were unable to visit. 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</p>
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	<p>Work Act 2015 including notifying staff when changes in practice or policies have occurred. An interview occurred with a Selwyn Oaks nominated staff health and safety representative, who is new in the role. The H&S representative was able to detail the position responsibilities which are also detailed in a signed job description. This includes hazard review and management, staff training and open communication. The hazard registers are available for staff. Staff knew the process for reporting any new hazards, and hazards are discussed at the health and safety meeting. The '10 golden rules' of health and safety are displayed throughout the facility.</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. Progress with meeting quality indicators is reviewed by the 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</p>
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		<p>for each site.</p> <p>A contracted off-site provider benchmarks infection control data.</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. 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 with resident related events are documented directly electronic resident management system in use. A sample of at least 11 incident forms verified appropriate events were reported, and incidents were investigated, and immediate action taken. Neurological monitoring has not occurred post unwitnessed resident falls according to policy for recent applicable sampled events. This is included in the area for improvement raised in criterion 1.2.3.8. Other sampled events demonstrated appropriate follow up.</p> <p>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 disclosure is documented as occurring for applicable sampled events and the GP informed in a timely manner where clinically indicated.</p> <p>The V&CM and ACM can review data of reported events per resident, or for a designated time period, or per category / type of event. The management team noted the search function for adverse events is very useful, along with the other functions that alert them of new and/or open events. Adverse event data is collated, analysed and electronic graphs/reports are generated, including monthly trends over the last 12 month period. This information is discussed at the staff meetings and displayed for staff in a designated area. The care partners confirmed</p>

		<p>being kept well informed of this information and the residents that are involved. The V&CM documents a narrative about any variations monthly.</p> <p>The V&CM described essential notification reporting requirements and detailed the type of events that are required to be reported. There have been five notifications to the Ministry of Health in 2021. These related to the loss of facility power (October 2021), a resident pressure injury (September 2021), and three events in May 2021 related to the call bell system. A permanent solution for the call bell issues has occurred. No 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>PA Moderate</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. New employees now also require a negative Covid-19 test prior to starting their orientation. The V&CM is assisted by designated staff from the support office with recruitment related activities. A sample of staff records reviewed confirmed the organisation's policies are being implemented and records are maintained. All employed and contracted registered health professionals have a current annual practising certificate, with records sighted.</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. Staff reported that the orientation process included individual resident's care needs, policy and procedures, health and safety, emergency preparedness and the facility/equipment, preparing them appropriately for their role. Staff records reviewed showed documentation of completed orientation, or the orientation programme was in progress.</p>

		<p>Performance appraisals are occurring for staff. The V&CM has a list that details when annual appraisals are due and completed. Work is ongoing to complete the remaining appraisals that were due in September 2021, with the majority of staff now completed. A variety of unforeseen circumstances have impacted the management team's ability to complete these earlier with their focus on ensuring residents' care needs were met during Covid-19 alert level restrictions. This is not raised as an area for improvement as good progress is being made, and the outstanding staff have appointments to meet with the V&CM.</p> <p>Staff are provided with regular ongoing education. However, ensuring staff complete requirements, and competency assessment records are maintained (where applicable) is an area requiring improvement.</p> <p>Five registered nurses (including the ACM) 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 Oaks adjusts staffing levels to meet the changing needs of residents. The V&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 partners 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 roster is issued at least two weeks in advance. If there are gaps in the roster, staff can opt to work an extra shift. The V&CM monitors the hours staff work. The Selwyn Foundation has an internal bureau with staff available for different roles for planned and unplanned absences. If shifts cannot be covered by Selwyn Oaks staff, assistance is sought from the Selwyn bureau, or an external agency (Covid-19 alert levels permitting). With the current Covid-19 precautions in place, designated Selwyn bureau staff are working at Selwyn Oaks only, in order to minimise risks associated with staff who would normally be moving between several Selwyn care facilities. Observations and review of a two weekly roster confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence in sampled rosters with infrequent exception. On occasions the 'house lead' has assisted the RN with medication rounds in the event of an unplanned RN absence, and a replacement RN was not available. An additional care partner was obtained for these shifts. A care partner, registered nurse and activities coordinator / diversional therapist position are anticipated to become vacant in the near future.</p> <p>In addition to the V&CM and the ACM who work weekdays, there are two RNs rostered on each morning shift, two RNs in the afternoon (usually one per floor AM and PM), and one RN on site at night. In addition to the care partner/house lead, eight other care partners are rostered for each morning shift (with one care partner per household normally working a slightly shorter shift), eight care partners in the afternoon (with one care partner per household working a shorter shift) and three care partners at night. There is a minimum of three care partners and a RN on duty. Applicable RNs are allocated time to complete InterRAI assessments / care planning requirements.</p> <p>Three housekeepers are on the care home roster covering seven days of the week. The activities coordinator normally works weekdays. The house lead is currently assisting with running the activities programme. An administrator works weekdays.</p> <p>Laundry services are provided by the Selwyn Laundry (off site). Catering services are provided by a contracted company. Maintenance services are provided by employed staff.</p> <p>At least one staff member on duty has a first aid certificate, as verified by</p>
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		<p>records sighted. The V&CM is currently arranging refresher training for those staff with certificates that expiry date was extended due to the absence of training opportunities during the most recent national Covid-19 alert level.</p> <p>There is one general practitioner providing services, with a visit occurring on site weekly and other appointments virtually. Contracted allied health staff have not been on site since the Covid-19 restrictions were implemented in August 2021, however, can be contacted for virtual / telephone consultations when required.</p> <p>Prospective provider: The integration plan describes no expected changes to the current configuration of staff at Selwyn Oaks. 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>There is a policy and procedure on records management. Records of current and previous residents are securely maintained electronically. Selwyn Oaks has been working hard to establish a paperless information system. Records reviewed evidenced demographic information is documented on entry. The admission process includes verification and documentation of individual resident's information. Residents' records sampled electronically included all reports from all health professionals and any hard copy records are scanned into the electronic system adopted by the organisation. Records are integrated in the one record for each individual resident. Progress records are maintained as required. A back-up system is available.</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>The entry to service policy includes all the required aspects on the management of enquiries and entry. These include Need Assessment Service Coordination (NASC) assessment, discharge summary and other required documents. Assessments and entry screening processes are documented and are clearly communicated to the residents, family/whanau where appropriate, local communities and referral agencies.</p> <p>Records sampled confirmed that admission requirements were conducted within the required timeframes and are signed on entry. Family and residents interviewed confirmed that they received sufficient information regarding the services to be provided. The organisation seeks updated information from the NASC and general practitioner for residents accessing respite care. Records 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 polymerase chain reaction (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 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 CMDHB 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>There is a comprehensive range of medication management policies and procedures. Policies include a reference to the Ministry of Health 2011 Medicine Care Guides for Residential Aged Care. Photographic identification on each medication record reviewed was current. All intolerances and allergies/sensitivities are 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. There is a process in place to assess that staff are competent to administer medications, however assessment records are not consistently maintained. This is included in the area for improvement raised in 1.2.7.5.</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 is provided six monthly and at any time required. There is a medication room on both floors of the clinical areas.</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 (last completed by the pharmacist on 25 November 2021) and accurate entries are documented in red ink. Emergency medications are checked monthly. Emergency grab bags are also available on both floors of the facility.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted included the prescriber's 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 medicines. The required three monthly GP review is 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 are in place to ensure this is managed in a safe manner if and when required.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</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>	FA	<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 on 24 September 2021. 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 registration authority the Ministry for Primary Industries (MPI). The food control plan expires 7 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 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, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p>
Standard 1.3.2: Declining Referral/Entry To Services	FA	If a referral is received but the prospective resident does not meet the

<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>		<p>entry criteria or there is no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed. 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 Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<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 Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Care plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed, and included mobility / falls risk and continence. Selwyn Oaks is transitioning to full electronic records. Electronic records only 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 is able to make a plan and the physiotherapist assistant (an experienced care partner) carries out the instructions provided for an individual resident. Any change in care required is documented and verbally passed on to relevant staff.</p>

		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>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>	FA	<p>Documentation, observations and interviews verified the care provided to residents was consistent with their needs, goals and the plan of care. Interventions for (e.g., wound care and continence issues are fully addressed). 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 level of care provided and in accordance with the residents' needs. Residents' continence needs are being identified and met. Falls prevention interventions are individualised and appropriate. The neurological monitoring of residents post an unwitnessed fall is not occurring as required by organisation policy, for the sampled events. This is included in the area for improvement raised in 1.2.7.5.</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>	FA	<p>The activities programme is provided by one trained diversional therapist (DT) holding the National Certificate in Diversional Therapy Level 4, a care partner who is currently completing the relevant training and care partners as able, and rostered volunteers. The rostered volunteers have been unable to participate during the pandemic and currently the DT is on leave. The service provides activities seven days a week. The experienced care partner (house lead) is covering the activities programme and is managing this well. Each house (four houses) has their own programme.</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 activities programme that is meaningful to the residents. The resident's activity needs are evaluated six monthly and as part of the formal six</p>

		<p>monthly care plan review.</p> <p>Activities reflected residents' goals, ordinary patterns of life and included 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 other feedback. Minutes of meetings were reviewed. Residents interviewed confirmed they find the programme meaningful and entertaining. However, with the 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>Resident 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 any infections. 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 for any changes 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 disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Residents are supported to access or seek referral to other health and/or disability service providers. The majority of residents are under the contracted GP. If the need for other non-urgent services is indicated or requested, the GP sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to the orthopaedic clinic, dietitian, hospice and/or other DHB services. The resident and the</p>

		<p>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 CMDHB services as arranged. Processes are in place should a resident be transferred back to Selwyn Oaks in respect of COVID -19.</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>	FA	<p>Staff follow documented processes for the secure storage and management of recycling, waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. Waste is collected at scheduled intervals by a contractor.</p> <p>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.</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.</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>	FA	<p>A current building warrant of fitness (expiry date 22 August 2022) is publicly displayed.</p> <p>The care home is comprised of three floors, with elevators to move between each floor. The main entrance / reception, chapel, a library / lounge, hair salon, activities lounge (contains some gym equipment), kitchen, restaurant, and staff office and service areas are located on the ground floor. The resident care areas are located on the first and second floors. The first and second floors have two households on each floor. The building footprint is reported to be the same for each floor. Each household has 12 residents' bedrooms with full ensuite bathrooms, and open plan lounge/living areas. There are ceiling mounted hoists in each</p>

	<p>bedroom. These were due for validation in November 2021; however, this could not be undertaken as scheduled due to the National Covid-19 alert levels in place at the time. Negotiations are occurring with the company to schedule a date for this to now occur as soon as possible, and copies of the email communications were sighted. There are designated rooms that have doors connecting to next bedroom which can be used where adjoining rooms are requested/required by residents. These doors are secured closed when not required.</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 some electrical equipment is overdue. However, this also could not occur as scheduled for the previously noted reasons and negotiations were underway to reschedule this. Selwyn Oaks provided the smaller / portable clinical items for clinical calibration and performance monitoring in October 2021 as scheduled as this could be undertaken without the service technician entering the building. Communications are in progress to obtain a date for the outstanding equipment to be reviewed. The above was verified in documentation reviewed, interviews with maintenance personnel and V&CM, 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 monthly and was within the required temperature range in sampled areas.</p> <p>There are two facility vehicles that are used for residents. These have current registration and warrants of fitness, and were undergoing their routine service during audit. 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 multiple areas residents and family can use (when permitted within the national Covid-19 alert levels), with furniture and shade. Each household has a covered deck area and there are several areas outside on the ground floor that is currently being used for residents to meet with visitors. 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</p>
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		<p>this was verified by staff and review of the maintenance request records.</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>	FA	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. Every bedroom has an ensuite bathrooms with shower, toilet and handbasin. There are other toilets on each floor for staff and visitors to use.</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 present.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely.</p> <p>All bedrooms are large enough to accommodate the resident and any staff or equipment required to assist residents when required. All bedrooms are for a single occupant,</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 and elsewhere in the facility for the resident and facility equipment and supplies to be stored.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate,</p>	FA	<p>A range of communal areas are available for residents to engage in activities on both floors including an open plan kitchen, dining and living room in each household. There is an activities lounge, chapel, hair salon,</p>

<p>and accessible areas to meet their relaxation, activity, and dining needs.</p>		<p>restaurant, library/lounge also on site. Each household also has a 'den'. This includes a pull-down wall mounted double bed that can be used by family members enabling them to stay and support a resident when needed (Covid-19 alert levels permitting), or used as a quiet space for residents.</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 as verified by staff, residents and family members interviewed.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>Laundry services are provided at the Selwyn Laundry facility in Auckland for the facility laundry and most of the residents' personal clothes. There is a daily pick up and drop off service. Staff receive, fold/iron and return clean laundry to the residents. There are laundry facilities (a washing machine, dryer and a portable drying rack) available for resident or family use on both the first and second floor. The washing machine has detergent inserted via auto dispenser. All residents are given six washing bags labelled with their household and room number. Resident garments are labelled the same. The clothes are washed and dried and returned remaining in their washing bags. Staff advise each laundry bag can be electronically tracked if required.</p> <p>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>Facility linen is delivered in designated containers with a list of the contents and the date the linen is to be placed into use. Staff note the systems work well and clean and dirty segregation is maintained.</p> <p>Housekeeping staff are on site seven days a week and have attended education on the safe handling of chemicals. Bulk chemicals were stored in a lockable cupboard. Housekeepers 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 housekeepers interviewed. There has been an increase in spot cleaning of high touch surfaces as part of the Covid-19 prevention</p>

		<p>activities.</p> <p>Housekeeping and laundry processes are monitored through the internal audit programme and through resident and family feedback.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Policies and guidelines for emergency planning, preparation and response are displayed 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 22 January 2018. Fire evacuation training and drills are usually conducted six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 19 April 2021. The October 2021 fire drill could not occur due to Covid lockdowns restrictions. However, the village and care manager is working 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 village and care manager to access images with appropriate prior organisation approval, and examples were provided of this occurring. An external security contractor undertakes several site visits afterhours.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas barbecue were sighted and meet the requirements for 48 residents. This meets the Ministry of Civil Defence and Emergency Management recommendations for the region. These supplies were checked in December 2021, and expiry dates of supplies noted. The maintenance personnel noted there is 1500 litres of water available in emergencies for the care home in addition to two 60 litre bottles of water.</p> <p>There is a connection onsite that enables a generator to be connected. A generator needs to be sourced off site when required.</p>

		<p>Call bells alert staff to residents requiring assistance. The call bell enables staff to identify when they are in the resident's room, and to call for assistance in an emergency. The call bells alert to staff pagers, and light up outside the room and on a central panel. There is a cascade escalation system in place to escalate calls to other staff and the management team if calls are not answered with established timeframes. 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 sufficient natural light and good ventilation. There are louvered windows in each bedroom that enables the resident to open or close for ventilation as required. The bedroom windows are large enabling bed ridden residents to be able to easily see outside from in their bed. There is centralised heating and air conditioning, and the temperature of rooms can be individually adjusted by designated staff if required. There is a gas fire in each of the household lounge/dining areas. 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 completed on the 7 December 2021.</p> <p>There is a designated infection prevention and control coordinator (ICC). The responsibilities and accountability for the role is clearly defined. The ICC reports directly to the care manager if there are any issues identified. In addition to this, any infection control matters, including surveillance results, are reported monthly to the clinical quality manager and tabled at the quality/risk committee meeting. On the 30 June 2021 the Selwyn Foundation presented a certificate of achievement award to Selwyn Oaks in recognition of having consistently low infection rates.</p>

		<p>A pandemic plan is developed for the Selwyn Foundation and all facilities have implemented the plan including Selwyn Oaks. The plan reviewed is based on the New Zealand COVID-19 protection framework. During COVID-19 lockdown an outbreak situation report was completed daily and monthly COVID -19 audits were completed.</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). Family are able to visit on an appointment basis only and this was observed during the audit. Personal protective equipment (PPE) is readily available, and all staff are 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 for approximately one year. The ICC has undertaken infection prevention and control training and attended relevant study days, as verified in training records sighted. The ICC registered nurse 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 is accessed from the infection control team at the Counties Manukau District Health Board (CMDHB), the pathologist at the community laboratory, the general practitioner (GP) and public health unit, as required. The ICC has access to residents' records and diagnostic results to ensure timely treatment and resolution</p>

		<p>of any infections.</p> <p>The ICC confirmed the availability of resources to support the programme and any outbreak of an infection, such as for COVID-19. All residents and family interviewed were kept well informed.</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 December 2021 and include appropriate referencing. The policies and procedures/guidelines for Covid-19 have been regularly updated. Additional policies and procedures include personal protective equipment (PPE) and safe usage, outbreak management, waste management, cleaning and disinfectant and surveillance activities. Staff were observed to be following the infection control standards which comply with relevant legislation and current good practice. Staff also demonstrated knowledge on the requirements of standard precautions and were able to locate policies and procedures. Hand washing and sanitiser dispensers are readily available around the facility.</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 and infection prevention and control is covered at the monthly staff meetings with education sessions. There was a corrective action (refer to 1.2.7.5) where a practical educational component was included as not being effectively met in relation to 'donning and doffing' of gowns (PPE).</p> <p>When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. An example of this occurred earlier this year when there was an outbreak of head lice. This provided a learning opportunity for all care partners, cleaning and laundry staff. During the 2020 and</p>

		<p>2021 nationwide pandemic periods ongoing education has been provided. Currently the service is operating and being managed under the New Zealand COVID-19 protection framework (traffic light system).</p> <p>Education with residents is provided generally on a one-to-one basis. Staff have had regular contact with residents' 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>	FA	<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. The food service catering manager interviewed is kept well informed and also maintains an outbreak case log by receiving daily updates, as to how many residents are in isolation, new suspected or confirmed COVID-19 affected residents (there have been none), admissions, discharges, transfer and if there are any restricted areas for household staff including kitchen staff to be aware of.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<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 V&CM and the assistant care manager confirmed restraint interventions would only be used where clinically indicated and justified, and alternative strategies have been</p>

		<p>tried and were ineffective. The ACM is the designated restraint coordinator at Selwyn Oaks, and responsibilities of this role are documented in a signed position description.</p> <p>The Selwyn Foundation has undertaken a quality initiative 'towards zero restraint'. The use of restraint and enablers is monitored via the internal audit programme and clinical indicator programme. The staff at Selwyn Oaks were recognised by The Selwyn Foundation in July 2021 for continuing to being a restraint free facility. Staff and managers interviewed advised it has been at least five years since restraints were used at Selwyn Oaks. Staff noted they implemented other initiatives including distraction / diversion, meaningful activities / engagement, and communication with residents and have avoided the need to use restraints. The restraint coordinators from the various Selwyn Care facilities formally meet at least annually.</p> <p>There were no residents 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 orientation and as part of the ongoing education programme.</p>
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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	<p>PA</p> <p>Moderate</p>	<p>Staff document corrective actions for any shortfalls identified through internal audits, incidents, staff meetings, hazard identification or feedback from residents or relatives. Evidence of corrective actions being implemented was observed in response to complaints, some internal audits and hazard management / maintenance requests. However, examples were sighted of corrective action plans that were documented and closed off the same day, despite some or all interventions yet to be completed. While some reminders were noted of actions required in the applicable manager’s electronic diary, this was not consistent. Selwyn Oaks has been working to improve the consistency of monitoring post</p>	<p>Some corrective action plans are prematurely documented as closed before all the required interventions have been implemented and monitored for effectiveness. Examples included post resident falls monitoring, aspects of staff training and following some internal audits.</p>	<p>Ensure when required improvements are identified, corrective action plans are documented, implemented and monitored for effectiveness prior to being closed.</p> <p>90 days</p>

		<p>resident falls, with a quality improvement plan developed earlier in 2021. The action plan is noted as closed. However, for all four recent unwitnessed resident falls sampled, while neurological monitoring occurred, there was variation in the frequency and duration. Monitoring was not occurring as required by the updated organisation policy (Refer also Standard 1.2.4). This sample size was widened during audit. Other examples were sighted in regard to staff training compliance follow up (refer to 1.2.7.5) and following some internal audits.</p>		
<p>Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	<p>PA Moderate</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. Where this outcome did not occur, the V&CM advised she contacted staff with a reminder to redo the test. However, staff have not recompleted the components as required. There were examples where some staff achieved less than</p>	<p>Some staff are not obtaining the required result (100%) for online learning modules completed.</p> <p>The competency assessment forms including donning and doffing personal protective equipment (PPE), hand hygiene (July 2021) and medicine competency (May 2021) have not been completed for applicable staff although the management team noted education and observations of some staff practices have occurred but not been documented.</p>	<p>Ensure staff complete the required online education programme and obtain 100% for each module as required by The Selwyn Foundation. Ensure practical competency assessments are conducted as and when applicable using the associated template forms and that records are retained.</p> <p>90 days</p>

		<p>required (100%), for education topics completed two or more months ago including medicine management. There are processes in place to monitor that staff are completing the required education modules and this is being reported to the clinical governance committee. The CQM advises this is currently a manual process.</p> <p>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. There is a competency assessment form to be completed during this process, with a template provided for the assessment. The V&CM advised staff were provided with donning and doffing and hand hygiene education during a staff meeting and this included observation of practice. However, the associated competency records were not completed for sampled events.</p> <p>The RNs and six applicable care partners were emailed the practical medical competency re-assessment forms. The ACM reported having undertaken some observations of applicable staff medication administration practices although the assessment records were not completed. At least one staff member administering or being a medication 'second checker', did not achieve</p>		
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		<p>100% in the 2021 medicine theory quiz. A new staff member advised they were not administering medicines as had yet to complete the organisation's medicine competency requirements.</p> <p>Staff meeting minutes detailed any education topics included in the meeting and this included current policy, procedures and expected practice.</p> <p>Staff interviewed confirmed they are provided with relevant ongoing education applicable to their roles.</p>		
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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.