

Selwyn Care Limited - Ivan Ward Centre

Introduction

This report records the results of a Certification 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 Health and Disability Auditing New Zealand 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:	Selwyn Care Limited
Premises audited:	Ivan Ward Centre
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 6 August 2019 End date: 7 August 2019
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:	70

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.

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

Key to the indicators

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

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

General overview of the audit

Selwyn Ivan Ward is part of The Selwyn Foundation Group. The facility is certified to provide rest home, hospital and dementia level care for up to 90 residents. On the days of audit there were 70 residents. All residents were on the age-related care contract.

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

Selwyn Ivan Ward is managed by an experienced care manager who previously worked as a clinical manager for Selwyn. She is supported by a senior registered nurse, and a village manager. The management team are supported by the group regional clinical quality manager and the operations manager.

There are systems being implemented that are structured to provide appropriate quality care for residents. An orientation and in-service training programme continues to be implemented that provides staff with appropriate knowledge and skills to deliver care. Residents and family advised that the staff provide a caring and homely environment.

This audit identified improvements required around; care plan documentation and care implementation.

A continued improvement is awarded around the safe, calm and effective move for all residents to the new facility.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.

Standards applicable to this service fully attained.

Policies and procedures adhere with the requirements of the Code of Health and Disability Services Consumers' Rights (the Code). Residents and families are informed regarding the Code and staff receive ongoing training about the Code.

The personal privacy and values of residents are respected. There is an established Māori health plan in place. Individual care plans reference the cultural needs of residents. Discussions with residents and relatives confirmed that residents and their families are involved in care decisions. Regular contact is maintained with families, including if a resident is involved in an incident or has a change in their current health. Families and friends are able to visit residents at times that meet their needs. Examples of good practice were provided.

There is an established system for the management of complaints, which meets guidelines established by the Health and Disability Commissioner.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.

Standards applicable to this service fully attained.

Services are planned, coordinated and are appropriate to the needs of the residents. The village and care manager is responsible for the day-to-day operations. Goals are documented for the service with evidence of regular reviews. A quality and risk

management programme is in place. Data is collected, analysed and discussed and changes made as a result of trend analysis. Quality improvement plans are developed when service shortfalls are identified.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. Ongoing education and training is in place, which includes in-service education and competency assessments.

Registered nursing cover is provided twenty-four hours a day, seven days a week. Residents and families reported that staffing levels are adequate to meet the needs of the residents.

The electronic integrated residents' files are appropriate to the service type.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Residents are assessed prior to entry to the service. There is an information pack available on admission. Assessments, care plans and interventions are the responsibility of the registered nurses. InterRAI assessment tools and monitoring forms are used to assess the level of risk and ongoing support required for residents. There are multidisciplinary reviews six monthly that involve the resident and relative. The GP reviews the residents at least three monthly. Referral documentation is maintained on resident files.

The activity programme includes participation in the village community activities and small group activities held in the households that meet the resident preferences. Activities in the dementia care house are individualised and meaningful.

There are medication management policies that direct staff in terms of their responsibilities in each stage of medication management. Registered nurses and care partners administer medications and complete annual competencies. The service uses an electronic medication system. The general practitioner reviews medication charts at least three monthly.

The menu is designed and reviewed by a registered dietitian. Meals are prepared and delivered from a site kitchen. Residents' individual needs are identified and accommodated. The households have fully functional kitchens where breakfast and meals are served and can be prepared as arranged.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building has a certificate for public use. The building is currently under warranty for all maintenance concerns. Chemicals are stored safely throughout the facility. All resident rooms are spacious with ensuites. Each household of 12 beds has a kitchen and open plan dining and lounge area. There is sufficient space to allow the movement of residents around the facility using mobility aids. The internal areas are able to be ventilated and heated. The outdoor areas are safe and easily accessible. Cleaners are providing appropriate services. Laundry is completed off site. Staff have planned and implemented strategies for emergency management. Emergency systems are in place in the event of a fire or other emergency. There is a first aider on duty at all times.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Staff regularly receive education and training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. A register is maintained by the restraint coordinator. Two residents were using restraints and no residents were using enablers at the time of audit.

Infection prevention and control

<p>Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.</p>		<p>Standards applicable to this service fully attained.</p>
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Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	48	0	0	2	0	0
Criteria	1	98	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>The Selwyn Foundation policies and procedures are being implemented that align with the requirements of the Code of Health and Disability Services Consumers' Rights (the Code). Families and residents are provided with information on admission, which includes information about the Code. Staff receive training around resident rights at orientation and annually as part of the mandatory training/education programme. Interviews with care staff (six care partners and three registered nurses) confirmed their understanding of the Code. Four residents (two rest home level and two hospital level) and five relatives (two hospital level, one rest home and two dementia) interviewed, confirmed that staff respect privacy and support residents in making choices.</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</p>	FA	<p>The service has policies and procedures relating to informed consent and advanced directives. All nine resident files reviewed (two rest home, four hospital and three dementia level of care) included signed admission agreements that included consents given for treatment, transport and outings, photographs and release of medical information. Specific consent forms were sighted for influenza vaccines and wound photographs. Advance directives where known were on the files. Resuscitation forms had been appropriately signed by the resident and their GP where residents were deemed competent to make a decision. Where residents were deemed incompetent to make a resuscitation decision the GP had made a medically indicated resuscitation decision. Discussion with residents and families identified that the service actively involves them in decision making. Enduring power of attorney (EPOA) had been activated in the three dementia resident files reviewed.</p>

consent.		
<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 provided with a copy of the Code and information about advocacy services on entry. Interview with the care manager and senior RN confirmed this occurs. Interview with residents confirmed that they are aware of their right to access advocacy. Interview with family members confirmed that the service provides opportunities for the family/EPOA to be involved in decisions. In the files reviewed, there was information on residents' family/whānau and chosen social networks.
<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	The activities policy encourages links with the community. This was seen to be implemented with the activity's programmes including opportunities to attend events outside of the facility. Residents and relatives interviewed informed visiting can occur at any time, and that the service encouraged involvement with community activities. Visitors were observed coming and going at all times of the day during the audit.
<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 service has a complaints policy that describes the management of the complaints process. Complaints forms are available in the foyer. Information about complaints is provided on admission. Interviews with residents and relatives confirmed their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints.</p> <p>A complaint register includes written and verbal complaints, dates and actions taken. A total of four complaints were received during 2019 year to date. There were no trends identified.</p> <p>Complaints are being managed in a timely manner, meeting requirements determined by the Health and Disability Commissioner (HDC). There is evidence a comprehensive follow up of all complaints is logged with complaints being discussed in management and staff meetings. All complaints received have been documented as resolved with appropriate corrective actions implemented.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed</p>	FA	There is an information pack given to prospective residents and families that includes information about the Code and the Nationwide Advocacy Service. There is the opportunity to discuss aspects of the Code during the admission process. Residents and relatives interviewed confirmed that information had been provided to them around the Code. A manager discusses the information pack with residents/relatives on admission. Families and residents are informed of the scope of services and any liability for payment for items not included in the

of their rights.		scope. This is included in the service agreement.
<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>	FA	<p>A tour of the premises confirmed there are areas that support personal privacy for residents. Staff were observed to be respectful of residents' privacy by knocking on doors prior to entering resident rooms. Staff could describe definitions around abuse and neglect that aligned with policy. Residents and relatives interviewed confirmed that staff demonstrate sensitivity in regard to resident privacy and dignity and where possible, encourage the resident to be involved in their care according to their ability. The recent survey confirmed that residents feel they are respected with a score 100% around respect.</p> <p>The service has a philosophy that promotes quality of life and involves residents in decisions about their care. Resident preferences are identified during the admission and care planning process and this includes family involvement. The recent survey scored 76% around resident/family involvement in care planning and 100% around resident choice. Interviews with caregivers described how choice is incorporated into resident cares.</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 Māori health plan policy for the organisation references local Māori health care providers regionally within New Zealand and provides recognition of Māori values and beliefs. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with disability and other community representative groups as requested by the resident/family. Cultural needs are addressed in residents' care plans and cultural needs scored highly at the recent resident survey. The service has two residents who identify as Māori. One file for a resident who identifies as Māori confirms their cultural needs are documented including liaison with a local kaumātua and links to the Ratana church. The Selwyn Village includes a cultural club for Māori residents.</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,</p>	FA	<p>An initial care planning meeting is carried out and the resident and/or whānau as appropriate are invited to be involved. Individual beliefs or values are discussed and incorporated into the care plans. Annual multidisciplinary team meetings occur to assess if needs are being met. Family are invited to attend. Discussions with relatives confirmed that residents' values and beliefs are considered. Residents interviewed confirmed that staff consider their values and beliefs.</p>

cultural, spiritual values, and beliefs.		
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Staff job descriptions include responsibilities. The monthly full facility meetings include discussions around professional boundaries and concerns as they arise. Management provided guidelines and examples of mentoring for specific situations. Interviews with the managers and care staff confirmed their awareness of professional boundaries. Care partners are trained to provide a supportive relationship based on sense of trust, security and self-esteem. Care partners from the dementia unit described how they build a supportive relationship with each resident. Interviews with two families from the dementia unit confirmed the staff assist to relieve resident's anxiety.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service focuses on providing and encouraging evidence-based practice. Registered nursing staff are available 7 days a week, 24 hours a day. A house GP visits the facility two days a week and provides an after-hours service from the on-site medical practice. The general practitioner (GP) reviews residents identified as stable every three months, with more frequent visits for those residents whose condition is not deemed stable. The GP interviewed is satisfied with the level of care that is being provided.</p> <p>The service receives support from the district health board, which includes nurse specialist visits. Physiotherapy services are provided by two registered physiotherapists twice a week for on-site five hours per week. A dietitian is also available for urgent consultations. A podiatrist is on site every six weeks. There is a regular in-service education and training programme for staff. The service has links with the local community and encourages residents to remain independent.</p> <p>The service is benchmarked against other villages within the Selwyn Foundation. If the results are above the benchmark, a quality improvement plan is developed by the service.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>There is an accident/incident reporting policy to guide staff in their responsibility around open disclosure. Staff are required to record family notification when entering an incident into the system. All 14 incident reports reviewed for June and July 2019 met this requirement. Family members interviewed confirmed they are notified following a change of health status of their family member. There is an interpreter policy in place and contact details of interpreters were available.</p>

<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Selwyn Ivan Ward is part of The Selwyn Foundation Group. The facility is certified to provide rest home and hospital (geriatric) and dementia level care for up to 90 residents. Seventy-two beds are dual purpose rest home or hospital and there are eighteen dementia beds. On the days of audit there were 70 residents. Twelve residents were receiving rest home level care and forty-one were receiving hospital care and seventeen were receiving secure dementia care (memory support unit). All residents were on the age-related care contract (ARCC).</p> <p>Selwyn Ivan Ward is a newly built facility within the Selwyn Village which was opened November 2018. The Selwyn Foundation has an overarching five-year strategic plan 2018 to 2022, which includes the model of care 'The Selwyn Way' which underpins how the Selwyn Foundation provides services within the context of its mission. There is a Selwyn Ivan Ward quality and business plan documented with new goals reflective of the new building and the household model of care. Documented goals reflect regular reviews via regular meetings.</p> <p>Selwyn Ivan Ward is managed by an experienced care manager who previously worked as a clinical manager for Selwyn. She is supported by a senior registered nurse, and a village manager. They are supported by the group regional clinical quality manager and the operations manager.</p> <p>The care manager has maintained at least eight hours of professional development activities related to managing an aged care facility.</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>	<p>FA</p>	<p>The senior registered nurse covers during the temporary absence of the care manager and supported by the village manager.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented,</p>	<p>FA</p>	<p>An established quality and risk management system has been fully implemented. Key performance areas are benchmarked against other Selwyn facilities and other providers. Quality improvement plans (QIPs) are developed when service shortfalls are identified, and these are monitored by group office. Quality and risk performance is reported across facility meetings, including staff meetings and RN meetings. Additional meetings include health and safety meetings, and infection control. The care manager also has meetings with</p>

<p>and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>the various designated coordinators including health and safety, infection control and restraint. Reports are provided to the group operational and clinical and quality manager.</p> <p>Resident meetings are monthly. Minutes are maintained. The service has commenced bi-monthly cheese and wine evenings with family, to assist communication and family linkages.</p> <p>Annual resident and relative surveys are completed with results communicated to residents and staff. An action plan has been documented for areas that did not achieve expected results. The agenda for the next resident meeting (August) includes the discussion of survey results.</p> <p>The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. The service's policies are reviewed at a national level by the Clinical Governance Group with input from facility staff every two years. Clinical guidelines are in place to assist care staff.</p> <p>Health and safety policies are implemented and monitored by the Health and Safety Committee. The Selwyn Ivan Ward health and safety committee meet on a monthly basis. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies.</p> <p>Falls prevention strategies are in place including (but not limited to): individual and group exercise programme; meeting individual toileting needs; sensor mats; use of perimeter guard mattresses; increased monitoring; identification and meeting of individual needs.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are 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>There is an incident/accident reporting policy that includes definitions and outlines responsibilities including: immediate action, reporting, monitoring, corrective action to minimise and debriefing. Individual incident/accident reports are completed for each incident/accident with immediate action noted and any follow-up action required.</p> <p>A review of 14 incident/accident forms (a sample from June and July 2019) identified that forms are fully completed and include follow-up by a registered nurse. Neurological observations did not always evidence that they had been consistently completed for unwitnessed falls as per policy (link 1.3.6.1). The village and care manager and senior registered nurses are involved in the adverse event process.</p> <p>The service maintains a separate file for all critical and more serious events. Six have been recorded for 2019. Four of the events required a section 31 report and these were documented (two pressure injuries and two residents leaving the premises for a prolonged period of time, with police involvement). All of the critical/more serious events documented an in-depth review and follow-up. There is a debriefing process for all critical incidents that includes a staff debrief and a review of the incident at the Clinical Governance Group.</p>

		<p>The group operations manager and village and care manager were able to identify situations that would be reported to statutory authorities including (but not limited to): infectious diseases, pressure injuries, serious accidents and unexpected death. Appropriate notification has been made as needed.</p> <p>There have been no infectious outbreaks at the new facility.</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>	FA	<p>There are comprehensive human resources policies in place. Seven staff files reviewed (the diversional therapist, two RNs, the driver and three care partners) included a comprehensive recruitment process including: reference checking, signed employment contracts and job descriptions, completed orientation programmes and annual performance appraisals. A register of registered nursing staff and other health practitioner practising certificates is maintained.</p> <p>The orientation programme provides new staff with relevant information for safe work practice. There is an implemented annual education and training plan that exceeds eight hours annually. The Selwyn Foundation have an online interactive video and quiz training programme known as Selwyn Learn which has been introduced. The training plan is implemented using a mixture of Selwyn Learn and on-site trainings. Two subjects a month are made available to staff with a requirement to correctly answer the online quiz. If staff do not pass one of the three attempts, the educator completes a one-on-one education session with the employee within one month of the training date. Incidental training is provided according to identified need and at staff request. There is an attendance register for each training session and an individual staff member record of training.</p> <p>There are ten staff who regularly work in the dementia unit. Nine staff have completed the required NZQA dementia education modules and one staff member who has been employed in the last six months has been enrolled.</p> <p>Registered nurses are supported to maintain their professional competency. Five of nine permanent registered nurses have completed their interRAI training. There are implemented competencies for registered nurses.</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</p>	FA	<p>A policy is in place for determining staffing levels and skills mix for safe service delivery. The care manager and a senior registered nurse are on duty Monday to Friday and on call as needed</p> <p>On the ground floor the dementia wing has separate staffing. There are further houses on the ground floor with one not yet opened.</p> <p>There are sufficient care partners (caregivers) rostered on duty each day to support the registered nurses and meet the needs of residents. Staff interviewed stated that overall the staffing levels are satisfactory and that the managers provide good support. Residents and family members interviewed reported there are sufficient staff</p>

<p>providers.</p>		<p>numbers.</p> <p>The dementia wing has 17 residents. An RN is rostered during the day, three days a week. On morning shift there is a senior caregiver/team leader rostered for the full shift and three caregivers (two long and one short). There are three caregivers rostered on afternoon shift (two long and one short) and one RN and one caregiver overnight.</p> <p>Household one (on the ground floor) has 6 of 12 beds occupied, all at rest home level. There are caregivers rostered for long shift and a short shift for the AM and PM shifts and one caregiver at night.</p> <p>Households three and four on the first floor are staffed together and caregivers allocated by the RN. There is an RN rostered for every shift. The households were full with 24 residents, all at hospital level. Staffing included: AM, four long shifts and one short shift, the house lead (senior caregiver) is part of the long shift. PM two long shifts and one short shift and two caregivers at night.</p> <p>Households five and six on the second floor are staffed together and caregivers allocated by the RN. There is an RN rostered for every shift. The households included six residents at rest home level and 17 residents at hospital level. Staffing included: AM, two long shifts and one short shift, the house lead (senior caregiver) is part of the long shift. PM three long shifts and one short shift and one caregiver at night.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access. Entries are legible, dated and signed by the relevant caregiver or nurse including designation. Individual resident files demonstrate service integration.</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</p>	<p>FA</p>	<p>All residents are assessed prior to entry for rest home or hospital level of care by a need's assessor. Residents are approved for entry to dementia care by the consultant psychiatrist or psychogeriatrician. The service has information available for residents/families/whānau at entry on the level of care and services provided. This includes specific information on dementia care and the secure environment.</p> <p>An admission agreement is signed on admission to the service and include how to access services that are not included in the agreement. The admission agreements reviewed aligns with a) – k) of the ARC contract. Nine signed admission agreements were sighted.</p>

identified.		
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>The service has transfer/discharge/exit policy and procedures in place. All transfer and discharge summaries are kept on the resident file. Relatives are informed and involved in discussions regarding transfers to hospital.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>There are medication management policies that align with required guidelines and legislation. The RNs and care partners are responsible for the administering of medication and complete medication competencies, syringe driver training and attend medication education. All medications are stored safely within each household. There is a locked central treatment room where impress supply and 'as required' medications are stored. Each household had a locked medication cupboard with a medication trolley and medication fridge. Restricted medications are accessed from one hospital level household. Medication fridge temperatures are maintained within the acceptable range. The RN checks all medications (robotic rolls) on delivery against the electronic medication chart which confirms medications have been reconciliated. All medication sighted was within the expiry dates and all eye drops were dated on opening. There are no self-medicating residents on the day of audit.</p> <p>Eighteen medication charts reviewed on the electronic medication system met legislative prescribing requirements. All medication charts had photo identification and allergy status identified. The GP had reviewed the medication charts at least three monthly.</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>A chef manager (interviewed) oversees the contracted food services for Selwyn facilities in the Selwyn site. Food services staff have completed food handling training and chemical safety. The main kitchen with a café is on the Selwyn site. There is an eight-week Selwyn menu that has been reviewed by a dietitian June 2019. The menu includes a resident choice. Special diets are accommodated including soft/mince and moist/pureed. Residents dislikes, food allergies are known and accommodated. The meals (in covered dishes) are transported in hot/cold scan boxes to the households where they are served by kitchen assistants. There is a kitchen assistant from 9 am - 6.30 pm daily in the dementia care house and kitchen assistants who are allocated to two households each. Each household has a fully functioning kitchen. The kitchen assistants prepare and serve breakfast, morning and afternoon teas and the main meals. Breakfast time was observed to be relaxing with residents attending the dining room at various times. The kitchen assistant accesses food items required from the main kitchen daily. There are nutritious snacks available in all households including the dementia care</p>

		<p>house.</p> <p>The food control plan has been verified and expires April 2020. Daily chiller/fridge (including the households), freezer, dishwasher and delivery of chilled goods temperatures are taken and recorded. End cooked temperatures are taken and recorded on main meals. A cleaning schedule is maintained.</p> <p>The chef manager attends resident meetings where residents have the opportunity to provide feedback on the meals. The menu has recently been reviewed in consultation with residents to accommodate likes and preferences. The residents interviewed were satisfied with the meals.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The reason for declining service entry to potential residents to the service is recorded. Should this occur, the service would communicate with the potential resident/family/whānau and the appropriate referrer. Potential residents would only be declined if there were no beds available or they did not meet the service requirements.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>The resident's needs, support requirements and preferences were collected and recorded on admission and formed the basis for the initial assessment and support plan. Information is also gathered from medical notes, discharge summaries, allied health involvement and from discussion with the resident/relatives on admission. The RNs complete applicable assessment tools on admission such as falls risk, pressure risk, dietary needs, continence, pain, mobility, cognitive and behaviour assessments. The outcomes of these assessments were reflected in the initial care plan.</p> <p>InterRAI assessments are completed at least six monthly or when there is a change to health status.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote</p>	PA Moderate	<p>Nine long-term care plans on the electronic Leecare system were reviewed. An initial plan of care was developed on admission for all resident files reviewed. The resident and/or relatives are involved in the development of care plans. The electronic progress notes document communication with the family regarding the development and review of care plans. Relatives interviewed confirmed they have been involved in care planning. The long-term care plans and care summaries are updated as changes occur to health, however not all care plans reflected current supports required. The care plans demonstrate allied health involvement in</p>

continuity of service delivery.		resident care.
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	PA Moderate	<p>When a resident's condition alters, the registered nurse initiates a review and if required GP or NP consultation. The residents and relatives interviewed confirmed their expectations were being met. There is evidence of communication with the relatives in the electronic progress notes including infections, medication changes, accidents/incidents, GP visits and any other changes to care.</p> <p>Adequate dressing supplies were sighted on the day of audit. There were wound assessments, wound treatment plans and wound evaluation forms in place for six dementia care residents and nine hospital level residents. Wounds included skin tears, one surgical wound and two chronic wounds. There were eight residents with pressure injuries on the day of audit (three community/hospital acquired, and five facility acquired). One resident had four facility acquired pressure injuries (three stage two and one stage three). There was adequate pressure injury equipment available and in use.</p> <p>Continence products are available. Bowel records are maintained. Specialist continence advice is available as needed and this could be described by the registered nurse. There are a number of monitoring forms used on Leecare to monitor the health status of resident's including blood sugar levels, behaviour charts, pain assessments, weight charts, blood pressure and pulse charts, food and fluid intake charts, re-positioning charts and continence monitoring. Care partners maintain daily hygiene and care provision records. Neurological observations had not been completed for unwitnessed falls.</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 diversional therapist (DT) has been employed since the opening of the service and oversees the activity programme for the households and the dementia care unit. There are two care partners who are currently progressing through the DT qualifications. There is an activity calendar for the households, used as a guide for care partners who initiate activities in each household each day to reflect the resident's preferences. The service is continuing to develop resources. There are integrated rest home and hospital level activities with an invitation to dementia care residents as appropriate and under supervision. There are several communal areas used for integrated activities including the games room, theatre room, café and village lounge. Regular activities are displayed with the location such as which household or communal area. Regular activities include body percussion, indoor bowling, reading revolution, laughter Yoga, colouring club, housie, poetry and performance, happy hours, chair yoga and chair Zumba. Other activities include music, knitting group, dance therapy, Tai Chi, discussion group, crafts, inter-house quizzes, card groups and pampering. There are entertainers, community visitors, church services and outings for all residents. There are integrated activities held in the village and there are six village volunteers involved in the household activities. Māori residents are invited to the Cultural Club held in the village and there is an integrated men's club.</p> <p>There is a separate activity programme for Brian Wells House (dementia care). Care partners initiate one-on-</p>

		<p>one or small group activities that are meaningful and flexible to meet the residents needs and preferences including pet therapy and baby buddy visits, arts and craft and colouring. Occupational therapy students visit weekly.</p> <p>The leisure and recreational assessments are completed on Leecare by the DT. Activity plans are reviewed six monthly as part of the multidisciplinary review. There are resident meetings which provide residents with an opportunity for feedback on all areas of the service. Residents interviewed commented positively on the activities offered.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Evaluation timeframes are specified in policies and procedures. There are six monthly written multidisciplinary care plan evaluations against the resident-focused goals for residents who had been at the service six months. A resident review record is kept on the resident file and includes input from the RN, GP, physiotherapist (as applicable), activities team, other allied health professionals as applicable and the resident/relative. The long-term care plans are updated following evaluation to reflect changes in care (link 1.3.5.2). The GP reviews the resident at least three monthly.</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>The service facilitates access to other services (medical and non-medical) and where access occurs, referral documentation is maintained. Residents and/or their family/whānau are involved as appropriate when referral to another service occurs. Registered nurses interviewed described the referral process should they require assistance.</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</p>	FA	<p>The service has documented policies and procedures for the safe and appropriate storage and disposal of waste and hazardous substances. Waste is appropriately managed. Chemicals were secured in a designated locked room. Chemicals were labelled and safety data sheets were available. There is a pre-mixed dispensing system for the refilling of chemical bottles. All staff have completed safe chemical handling training. Personal protective equipment/clothing was sighted in the sluice rooms. Staff were observed wearing protective equipment when carrying out their duties and demonstrated knowledge of handling chemicals.</p>

<p>result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>		
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The service displays a certificate of public use certificate that was issued 24 October 2018. The building will be handed over to Selwyn in November 2019. The facility maintenance manager (interviewed) covers all of the Selwyn facilities on the site. He has a maintenance team who are allocated to the facilities. Any maintenance requests are currently referred to the main contractor as the building is still under warranty. Selwyn Foundation has maintenance plans in place that include the checking of resident equipment and calibrating of medical equipment. A planned maintenance plan for the internal and external building will be put in place from November 2019. There are essential contractors available 24 hours. Hot water temperatures in resident ensuites are monitored and recorded monthly.</p> <p>There are six households. Two households and the dementia are housed are on the ground floor with four households on the first floor. Each household has spacious communal lounges and dining areas. There is sufficient space for residents to mobilise safely with the use of mobility aids. There are outside areas with seating, tables and shaded areas that are easily accessible. The upstairs households have balconies with seating and overhead shade.</p> <p>The dementia care house is on the ground floor, is spacious with indoor walking areas and access to secure gardens and grounds.</p> <p>Care partners interviewed stated they had sufficient clinical equipment to safely deliver care as described in the care plans including chair scales, electric beds, hoists and ceiling hoists in all resident rooms.</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</p>	<p>FA</p>	<p>All resident rooms have shower/toilet and handbasin ensuites. There are communal toilets close to communal activity areas. Communal toilet facilities have privacy locks.</p>

personal hygiene requirements.		
<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>There are six households each with 12 resident rooms. The rooms are spacious and allow adequate space for care to be provided and for the safe use and manoeuvring of mobility aids including hoists and wheelchairs. The resident rooms have individualised décor and furnishings. Residents are encouraged to personalise their rooms as viewed on the day of audit. All residents' rooms in the dementia care house are spacious and personalised.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>The ground floor has community areas for residents living in the households. This includes a large activity lounge/theatre, games rooms shop and hairdressing salon.</p> <p>Each household has a functional kitchen with a central island facing the dining area promoting socialisation and conversation while preparing/serving meals. There are large dining spaces with two lounge areas in each household. Each household has a "den" (family room) where visitors/family can meet, or quieter activities can take place. The "dens" have a fold away bed to accommodate family as required. The dementia care house has lounge seating arranged where small group or quieter activities can take place.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>All personal laundry and linen are completed off-site at a central laundry. There is a small domestic laundry available for woollens. Dirty laundry bags are sent downstairs via a chute in the sluice rooms to a designated collection point. There is a daily pickup of dirty laundry and drop off of clean linen trolleys. There was adequate linen sighted in linen cupboards. Residents and relatives expressed satisfaction with cleaning and laundry services.</p> <p>The service employs designated cleaners. The cleaning trolleys have locked chemical boxes built into the trolley. All trolleys are kept in designated areas when not in use. Cleaning and laundry processes are monitored for effectiveness through internal audits and feedback from residents. Staff have completed chemical safety training.</p>
<p>Standard 1.4.7: Essential, Emergency,</p>	FA	<p>The site-specific emergency manual contains the emergency and disaster policies and procedures including (but not limited to) fire and evacuation and dealing with emergencies and disasters.</p>

<p>And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>		<p>The fire evacuation scheme has been approved by the NZFS, 20 September 2018. There are fire curtains situated around the internal lounge/dining area that are activated in the event of a fire to make the area a fire cell. Trial fire evacuations were last completed May 2019.</p> <p>There is first aid trained staff across each shift.</p> <p>The service has cooking facilities (a barbeque) available in the event of a power failure. The service has access to a generator available in the event of a power failure for emergency power supply. Battery operated emergency lighting is in place. There are also extra blankets available. There is a civil defence storage area, which includes all necessary civil defence requirements. There are emergency tanks of water available. An effective call system is implemented</p> <p>CCTV cameras have been installed to monitor main corridors and exits; these do not impinge on resident privacy. A security company monitors the facility overnight. External doors are locked overnight during the hours of darkness.</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>Residents are provided with adequate natural light, safe ventilation and an environment that is maintained at a safe and comfortable temperature. The facility has underfloor heating throughout all areas which is centrally controlled. There are also heat pumps in communal areas.</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 is implementing the Selwyn infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system and the Selwyn key performance indicators. The senior registered nurse is the designated infection control nurse. Infection control is discussed at the monthly staff meeting and the infection control nurse and clinical manager meet at least monthly to discuss infection control and any issues. Minutes are available for staff. Audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation.</p>

<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The senior registered nurse at Selwyn Ivan Ward is the designated infection control (IC) nurse. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC coordinator and IC team (includes H & S team members and RNs as part of the staff meeting) have good external support from the local laboratory infection control team, IC nurse specialist at the DHB and Bug Control. Infection prevention and control is included as part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</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>There are Selwyn Foundation infection control policies and procedures appropriate for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies were developed by the Selwyn clinical governance and have been reviewed and updated.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff,</p>	FA	<p>The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred. The infection control coordinator has completed infection control training through the local DHB and Bug Control. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.</p>

and consumers.		
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Infection surveillance and monitoring is an integral part of the infection control programme and is described in the infection monitoring policy. The registered nurse is the designated infection control nurse and has the responsibility for the collecting of infection control data based on signs and symptoms of infection. Infections are individually logged on the electronic database and benchmarked against other Selwyn facilities. The data has been monitored and evaluated monthly. Data is reported to the management and staff meetings. Meeting minutes are available in the staff office. Infections are analysed for trends and corrective actions initiated where required.</p> <p>There have been no outbreaks since the opening of the building.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The restraint minimisation policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. The policy includes comprehensive restraint procedures. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. The restraint standards are being implemented and implementation is reviewed through internal audits, facility meetings, and restraint meetings at an organisational level. Interviews with the staff confirmed their understanding of restraints and enablers.</p> <p>Enablers are assessed as required for maintaining safety and independence and would be used voluntarily by the residents. On the day of audit, the service had two residents using restraint and no residents with an enabler. One resident was new and had new restraint (chair brief) and one resident also with a chair brief restraint had a documented trial of removal of restraint that was not successful.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and</p>	FA	<p>The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator (a registered nurse) and for staff are documented and understood. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements.</p>

others.		
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>A restraint assessment tool is completed for residents requiring an approved restraint for safety. Assessments are undertaken by the restraint coordinator in partnership with the RNs, GP, resident and their family/whānau. Restraint assessments are based on information in the care plan, resident/family discussions and observations.</p> <p>Ongoing consultation with the resident and family/whānau are evident. Two hospital level residents' files where restraints are in use were selected for review. The completed assessment considered those listed in 2.2.2.1 (a) - (h).</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint.</p> <p>Restraint authorisation is in consultation/partnership with the resident, family and the GP. The use of restraint is linked to the residents' care plans. Internal restraint audits measure staff compliance in following restraint procedures. Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Monitoring was evidenced to be consistently documented on the two restraint monitoring records reviewed.</p> <p>A restraint register is in place providing an auditable record of restraint use and is completed for all residents requiring restraints and enablers.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations are conducted monthly and restraint use is discussed monthly at registered nurse, staff and quality management meetings. A review of two resident files identified that evaluations are up to date. The service provided evidence where evaluation of the need for the use of restraint was evaluated and removal of a restraint was trialled unsuccessfully for one resident.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality</p>	FA	<p>The restraint minimisation programme is discussed and reviewed at the annual organisation-wide restraint coordinators meetings, monthly registered nurse meetings, monthly full facility and wing staff meetings. Meeting minutes include (but are not limited to): a review of the residents using restraints or enablers, updates (if any) to the restraint programme and staff education and training.</p>

review of their use of restraint.		
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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 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA</p> <p>Moderate</p>	<p>Care plans identify the resident supports and required interventions to meet the resident goals. Interventions for daily activities of living and recreation are focused around promoting and maintaining independence within a household model of care. Four of nine care plans did not reflect the resident’s current health status.</p>	<p>Not all interventions had been documented to meet the resident’s current health status as follows; (a) one rest home resident did not have a pain management plan for chronic back pain requiring analgesia, (b) another rest home resident did not have a pain management plan for back chronic pain and acute leg pain. The same resident did not have the presence of pedal oedema (as per GP notes) documented in the care plan, (c) there were no falls prevention strategies documented in the care plan for one hospital resident at risk of falls and who had three falls in two months and (d) one chronic wound was not documented in the long-term care plan for one hospital level resident.</p>	<p>Ensure all interventions are documented to support the resident’s current needs and supports.</p> <p>90 days</p>

<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Moderate</p>	<p>Non-healing wounds over four weeks and chronic wounds, are referred to the district nursing service or wound nurse specialist at the DHB, however for one resident with four facility acquired pressure injuries (including a stage three) there was a delay in accessing specialist input. The same resident was at risk of undernutrition and had unintentional weight loss. Neurological observations are required to be completed following unwitnessed falls, however these had not been completed for unwitnessed falls.</p>	<p>(1) There was a delay in wound nurse referral for one resident with a facility-acquired stage three pressure injury. The same resident was identified at risk of undernutrition and had unintentional weight loss. There was a delay in accessing dietitian input and (2) seven of seven unwitnessed falls did not have neurological observations completed as per protocol.</p>	<p>(1) Ensure wound nurse and dietitian advice is sought for residents with deteriorating pressure injuries and unintentional weight loss; (2) ensure neurological observations are completed as per protocol for unwitnessed falls.</p> <p>90 days</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, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.1.12.2 Consumers are supported to access services within the community when appropriate.	CI	<p>The service built a purpose-built facility last year and a project was developed and implemented around the transferring the existing residents from the old facility to the new facility. To ensure that residents had a smooth transition into the new care home, there was a working group put together to plan a suitable process about six months prior to the move. The aim was to minimise or prevent any anxiety or distress it may cause residents and their families and ensure everyone has a positive experience.</p> <p>Monthly information and update sessions with residents and families on the new care home and The Selwyn Way were implemented. Residents were involved in choosing colours for furniture and door colours in the dementia unit. There was a planned resident orientation and practice runs (meal services, getting rooms ready, lots of visits) in the new care home prior to the opening date and residents moving in. Therefore, residents, family and staff were able</p>	<p>To ensure that residents had a smooth transition into the new care home, there was a working group put together to plan a suitable process about six months prior to the move. The process ensured that residents and their relatives were kept informed and supported, and also allowed for both resident engagement and participation, the opportunity of maintaining established friendships to promote continued relationships was enhanced.</p> <p>The post move evaluation documents that the move was a positive experience and family and residents felt an improvement in resident’s quality of life since the move into the new care home and the household model of care. There were no behaviours that challenge reported, and staff felt that the teamwork</p>

		to take belongings into the new build and set room up before the day for the move	had been very good.
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End of the report.