

Mary Doyle Healthcare Limited - Mary Doyle Lifecare

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

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

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

The specifics of this audit included:

Legal entity: Mary Doyle Healthcare Limited

Premises audited: Mary Doyle Lifecare

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

Dates of audit: Start date: 10 June 2021 End date: 11 June 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: 154

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

Mary Doyle Healthcare Limited - Mary Doyle Lifecare is part of the Arvida Group. The service is certified to provide rest home, hospital, and dementia level care for up to 161 residents. On the day of the audit there were 154 residents.

This certification audit was conducted against the relevant Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of resident's and staff files, observations and interviews with residents, relatives, staff, and management.

Mary Doyle Lifecare is managed by an acting village manager who is suitably qualified and experienced. The manager is supported by support office staff and care managers who provide leadership for each unit. There are established quality systems and processes being implemented. The nurse practitioner, residents and relatives interviewed are very satisfied with the care and services provided.

The service has been awarded a rating of continuous improvement for the activities programme.

Improvements are required around advance directives, the quality programme, performance appraisals, care planning, and interventions.

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.		Some standards applicable to this service partially attained and of low risk.
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Policies are documented to support resident rights and residents stated that their rights are upheld. Individual care plans include reference to residents' values and beliefs. Residents and relatives are kept up to date when changes occur or when an incident occurs. Systems are in place to ensure residents are provided with appropriate information to assist them to make informed choices.

A complaints policy is documented that aligns with the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). A complaints register is maintained. Consents are documented by residents or family.

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.		Some standards applicable to this service partially attained and of low risk.
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The Arvida philosophy and vision is a new 'wellness model' which is based around a household model of care. The acting village manager provides overall leadership and operational management with support from the support office including the national quality manager for wellness and care. There are care managers who lead the teams working in each unit.

The service has a documented quality and risk management programme with key components of the system including management of complaints, implementation of an internal audit schedule, annual satisfaction surveys, incidents and accidents, review of infections, and review of risk and monitoring of health and safety, including hazards. Quality data is discussed at facility meetings.

Human resource policies are in place, including a documented rationale for determining staffing levels and skill mixes. A roster provides sufficient and appropriate staff coverage for the effective delivery of care. An orientation and training programme is documented and implemented. Registered nursing cover is provided 24 hours a day, 7 days a week.

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 low risk.
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Residents' records reviewed, provided evidence that the registered nurses utilise the interRAI assessment to assess, plan and evaluate care needs of the residents. Care plans are developed in consultation with the resident and/or family. Care plans are reviewed at least six-monthly. Resident files included medical notes by the contracted general practitioner, nurse practitioner and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. All staff responsible for administration of medication complete education and medication competencies. The medication charts are reviewed at least three-monthly by the general or nurse practitioner.

An activities programme is implemented that meets the needs of the residents. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical, and cognitive abilities and preferences for each consumer group. In the dementia care units is resident-focused and planned around everyday activities.

All cooking and baking is done on site. Residents' nutritional needs are identified and documented. Choices are available and are provided. An external dietitian reviews the organisation's menu plans.

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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Mary Doyle Lifecare has two buildings. One building provides rest home and hospital level of care. The other building provides a hospital level unit and two dementia care units. Both buildings have current building warrant of fitness certificates. Resident rooms are single, personalised, and spacious with an ensuite. The environment is warm and comfortable. There is adequate room for residents to move freely about the home using mobility aids.

Communal areas are well utilised for group and individual activity. The dining and lounge-seating placement encourages social interaction within the rest home, dementia, and hospital areas. There are quieter areas in the dementia care units appropriate to meet the individual needs. There are outdoor areas that are safe and accessible. There is a reactive and planned maintenance schedule in place. The main site laundry operates throughout the day. The cleaning service maintains a tidy, clean environment. Staff are trained in emergency management procedures. The service is well prepared in the event of an emergency.

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.

Restraint minimisation and safe practice policies and procedures are in place. Staff are provided with access to training in restraint minimisation and challenging behaviour management. At the time of audit there were six residents using restraints and five residents using an enabler. The approval process for restraint use includes ensuring the environment is appropriate and safe. Assessments and care plans identify specific interventions or strategies to try (as appropriate) before restraint is used. Restraint use is reviewed a minimum of three-monthly.

Infection prevention and control

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

Standards applicable to this service fully attained.

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. Documented policies and procedures including Covid resources are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. Infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Results of surveillance are acted upon, evaluated and reported to relevant personnel. Organisational benchmarking occurs. There is sufficient personal protective equipment available in the event of an outbreak.

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	1	45	0	4	0	0	0
Criteria	1	96	0	4	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in visible locations throughout the facilities. The service provides families/whānau and residents with information on entry to the service and this information includes details relating to the code of rights. Staff receive training about the Code at induction and through ongoing in-service training. Staff interviewed included seven caregivers, nine registered nurses, one enrolled nurse, kitchen manager, maintenance staff, wellness leader, activities assistant, restorative therapist, home assistant, health and safety representative, learning coordinator, village care coordinator, household assistant, payroll administrator. Managers were also interviewed including the acting village manager, national quality manager, and three care managers. All interviewed were able to describe services provided as being as per consumer rights legislation and policy.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice	PA Low	There are policies and procedures around informed consent, resuscitation status, advance directives, and enduring power of attorney (EPOA). Informed consent is discussed with residents and families on admission as confirmed in resident and relative interviews. General informed consent is included in the admission agreement sighted in the 13 resident files reviewed. Specific consent forms were signed for influenza and Covid-19 vaccines.

<p>are provided with the information they need to make informed choices and give informed consent.</p>		<p>Resuscitation forms have been appropriately signed in the rest home and hospital level files. There is evidence of discussion with family when the GP has completed a clinically indicated 'not for resuscitation' order. Advanced directives include hospital admission, active treatments and resuscitation which were correctly completed by the resident for hospital and rest home files reviewed, however not all advance directives were signed appropriately for dementia care residents.</p> <p>Caregivers and registered nurses interviewed confirmed verbal consent is obtained when delivering care. Family members stated they are involved in decisions that affect their relative's lives. All thirteen resident files reviewed had a signed admission agreement.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Health and disability advocacy information is included in the information provided to new residents and their family/whānau during their entry to the service. Brochures and contact numbers are available to residents and family.</p> <p>Residents interviewed were aware of the role of advocacy services and their right to access support. The complaints process is linked to advocacy services. Staff receive education on the role of advocacy services during their induction to the service and ongoing, as part of the annual education plan.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Residents may have visitors of their choice at any time. The service encourages the residents to maintain relationships with their family, friends, and community groups by encouraging their attendance at functions and events and providing assistance to ensure that they are able to participate in as much as they can safely and desire to do. Resident meetings are held, and residents interviewed stated that they are forums that encourage discussion. Family of residents in the dementia unit are also encouraged to engage in activities with their family member.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The complaints procedure is provided to residents and relatives on entry to the service. Discussions with residents and relatives confirmed they were provided with information on complaints on admission to the service and at intervals during resident/family meetings. Complaints forms are in a visible location at the entrance to the facility. All residents and family interviewed confirmed that they have no complaints.</p> <p>The acting village manager/clinical manager maintains a record of all complaints, both verbal and written. One complaint was received in 2020 and this was reviewed with confirmation that appropriate follow-up actions had been taken with resolution of the complaint to the satisfaction of the complainant. There had not been any complaints lodged in 2021. Caregivers interviewed commented that complaints are part of the meeting agenda</p>

		<p>and are discussed at various facility meetings with this sighted in meeting minutes reviewed.</p> <p>There have not been any complaints lodged by external providers.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>There is a welcome pack that includes information about the Code. There is opportunity to discuss aspects of the Code during the admission process with the resident, family and as appropriate their legal representative. The Code and advocacy pamphlets are clearly displayed at the facility entrance and on noticeboards throughout the hospital, rest home and dementia units. Large print posters are also displayed throughout the three areas.</p> <p>The Code, advocacy information and information on complaints/compliments is brought to the attention of residents and families at admission, in the information pack, via the monthly resident meetings and the six-monthly relatives' meetings. Mary Doyle Lifecare provides an open-door policy for concerns and/or complaints.</p> <p>Nine relatives (three dementia care, three hospital level and three rest home) and 15 residents (5 rest home level and 10 hospital level) interviewed stated they were provided with information on admission which included the Code.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Residents and relatives interviewed were positive about the service in relation to their values and beliefs being considered and met. Resident files and care plans identified residents' preferred names.</p> <p>Caregivers were observed to knock on doors before entering resident bedrooms. Care staff confirmed they promote the residents' independence by encouraging them to be as active as possible. Residents and relatives interviewed during the audit confirmed that the residents' privacy is respected.</p> <p>The residents' personal belongings are used to decorate their rooms as viewed on the day of audit.</p> <p>Resident's cultural, social, religious, and spiritual beliefs are identified on admission and included in the resident's care plan/activity plan, to ensure the resident receives services that are acceptable to the resident/relatives.</p> <p>Values and beliefs information is gathered on admission with family involvement and is integrated into the residents' care plans. Training around privacy and dignity was provided in 2020 and 2021.</p> <p>There is a policy around abuse and neglect. Staff receive training around abuse and neglect. Care staff interviewed were able to discuss ways in which they would manage suspected abuse or neglect. Staff, managers, and the nurse practitioner interviewed confirmed that there is no evidence of any abuse or neglect.</p>
<p>Standard 1.1.4: Recognition Of Māori</p>	FA	<p>Mary Doyle Lifecare has a Māori health plan in place. There is a range of supporting policies that acknowledge the Treaty of Waitangi and provide recognition of Māori values and beliefs. They value and encourage active</p>

<p>Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>		<p>participation and input of the family/whānau in the day-to-day care of the resident.</p> <p>During this audit, there were two Māori residents living at the facility. There are established links with Te Wahanga Hauora Māori Health Services, Hawkes Bay District Health Board with advice able to be provided as required. Any specific cultural needs are recorded in the resident's care plan with staff able to describe these.</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>The service identifies the residents' personal needs, culture, values, and beliefs at the time of admission. This is achieved in collaboration with the resident, family and/or their representative. Beliefs and values are incorporated into the residents' care plans in resident files reviewed. Residents and family/whānau interviewed confirmed they were involved in developing the residents plan of care, which included the identification of individual values and beliefs. There was documented evidence of the service acknowledging other cultures around values, beliefs, religion, and food.</p> <p>The service provides a culturally appropriate service by identifying any cultural needs as part of the assessment and planning process. Staff recognise and respond to values, beliefs, and cultural differences. Residents are supported to attend church services of their choice and are supported to attend other cultural community groups as desired.</p>
<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 described implementation of policies and processes around boundaries relating to discrimination, abuse and neglect, harassment, and exploitation. Training includes discussion of the staff code of conduct and prevention of inappropriate care. Staff interviewed stated that they were aware of the policies and were active in identifying any issues that relate to the policy.</p> <p>Job descriptions include responsibilities of the position and signed copies of all employment documents are included in the staff files sampled. Staff comply with confidentiality and the code of conduct. The employee agreement provided to staff on induction includes standards of conduct. Interviews with staff confirmed their understanding of professional boundaries, including the boundaries of the caregivers' role and responsibilities. Monthly staff meetings include discussions on professional boundaries and concerns as they arise (minutes sighted).</p>
<p>Standard 1.1.8: Good</p>	FA	<p>The service promotes evidence-based practice and encourages good practice. Registered nursing staff are available 24 hours a day. A nurse practitioner or general practitioner visits the facility three days a week. The</p>

<p>Practice</p> <p>Consumers receive services of an appropriate standard.</p>		<p>general practitioner (GP) or nurse practitioner reviews residents identified as stable every three months, with more frequent visits for those residents whose condition is not deemed stable.</p> <p>The service receives support from the district health board, which includes visits from the mental health team and nurse specialist visits as required. Physiotherapy services are provided on site for two hours per week with the support of a full-time physiotherapy assistant. The service has links with the local community and encourages residents to remain independent.</p> <p>Facility meetings occur regularly (as sighted). Staff are kept informed on all facility and clinical matters. Residents and family interviewed stated that they are kept well informed around Covid-19. Discussions with residents and family were positive about the care they receive. The nurse practitioner interviewed praised the service for care provided.</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>Management promote an open-door policy. Relatives/residents are aware of the open-door policy and confirmed on interview that the staff and management are approachable and available. Residents have the opportunity to feedback on service delivery through monthly resident meetings and the annual resident/relative survey.</p> <p>A total 23 accident/incident forms reviewed, evidenced relatives are informed of any incidents/accidents. Relatives interviewed stated they are notified promptly of any changes to resident's health status.</p> <p>Residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement. An interpreter service is available if required.</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>Mary Doyle Healthcare Limited - Mary Doyle Lifecare provides hospital (geriatric and medical), rest home and dementia level care for up to 161 residents. All bedrooms in the hospital/rest home units are dual purpose. On the day of audit, there were 154 residents in the service including 45 residents identified as requiring rest home level of care; 47 requiring hospital level of care; and 62 residents in the dementia units.</p> <p>The service is divided across five separate units; two dementia units (64 beds including Ashcroft with 34 beds with an occupancy of 32 residents, and Goddard with 30 beds with an occupancy of 30 residents); one rest home only unit (Bramlee with 34 beds) with an occupancy of 34 residents requiring rest home level of care; and two units (Reeve with 37 beds and Nimon with 23 beds) with a combination of residents requiring hospital and rest home level of care (Nimon with 17 hospital and five rest home residents, and Reeve with 30 hospital and six rest home residents. There are three serviced apartments noting that these were not occupied on the day of audit.</p> <p>The service has the following contracts: Long Term Support - Chronic Health Conditions (CHS-CHC) with three residents under this contract (one requiring dementia level of care, one under this contract at rest home level of care, and one under this contract at hospital level of care); Restore in ARRC Residential Care Services known as</p>

		<p>Engage (no residents funded by this contract on the day of audit); there was no-one requiring respite services; two partially funded under the Age Related Residential Care (ARRC) contract and ACC; and all others under the ARRC agreement.</p> <p>A vision, mission statement and objectives are in place. Annual goals for the facility have been determined, which link to the overarching strategic plan.</p> <p>The acting village manager has nine years' experience as a registered nurse with five years in aged residential care. He has a postgraduate certificate relating to nursing leadership and management. They are supported by management including the national quality manager in wellness and care, and three care managers who provide leadership in the units. All managers have maintained over eight hours annually of professional development activities related to managing an aged care service and clinical management.</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 most senior care manager is identified as the second in charge should the acting village manager be on leave. They would be supported by the national quality manager in wellness and care, and another care manager would step up to cover the unit that the second in charge leads. All interviewed were aware of their duties should they be required to take a leadership role.</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 Low	<p>An established quality and risk management programme is in place. Interviews with the managers and staff reflected their understanding of the quality and risk management. There was a business plan that has been reviewed for 2020 with the business plan for 2021 now in place. Upper management at support office including the chief executive officer, the chief financial officer and the national quality manager for wellness and care reviewed the last plan prior to the documentation of the 2021 plan. The plan includes quality goals and risk management plans for Mary Doyle Lifecare. The acting village manager is responsible for providing oversight of the quality programme on site, which is also monitored at organisational level.</p> <p>All policies/procedures are prepared and uploaded to the Arvida Intranet and are accessed by staff using the laptops and computers available to all staff. Hard copies are at this stage still made available on site. Each document identifies an approver (coordinated at support office), following input from internal experts, such as clinical/care managers (for clinical policies, or external providers used as subject matter experts. All policies/procedures are approved prior to distribution and use. All staff are notified of changes or updates to</p>

		<p>policies/procedures as they occur, via a weekly intranet update email notice, which contains the relevant intranet link. All policies and procedures are reviewed at least every two years noting that this does not exclude earlier review where changes in internal process, procedure, or industry standards and/or best practice occur. Changes to documents may also occur as a result of internal audit and process improvement initiatives. Any policy or procedure documents, no longer current/in use are removed and archived.</p> <p>The monthly monitoring, collation and evaluation of quality and risk data includes resident falls; infection rates; complaints received; restraint use; pressure injuries; wounds; and medication errors. An annual internal audit schedule was sighted for the service, with evidence of internal audits occurring as per the audit schedule in 2021. Quality and risk data, including trends in data and results are discussed in relevant meetings. Corrective actions are not always documented when issues are identified. At times, corrective action plans are documented, however evidence of resolution of issues is not always documented.</p> <p>There are monthly management reports to head office. There are a range of meetings held to discuss issues and data. These include the monthly individual household meetings, activities meetings, quality meetings, food services, maintenance, health and safety, infection control, restraint and other as required. There is a monthly business meeting that includes village managers from across the Arvida Group; and monthly clinical managers meeting with managers from across the Arvida Group. A residents meeting occurs, and an annual resident survey is completed. The last survey completed in February 2021 had 66 respondents. Those responding were highly satisfied in areas relating to safety and security, grounds, accommodation, clinical care, and cleaning, with corrective actions put in place to address lower satisfaction in food services and management.</p> <p>Since the last audit, the service has identified improvements in the following: the transition to the Arvida Wellness Model of Care has been implemented. This involves the incorporation of the five pillars of living well – eating, moving, resting, thinking, and engaging well, to the daily lives of the residents. Wellness activities in the dementia units has promoted individual preferences and independence had been greatly improved. Clinical documentation and reporting have improved as a result of the introduction of eCase in all the care households. Interviews with staff and review of meeting minutes/quality corrective action forms/opportunist education sessions, demonstrated a culture of quality improvements.</p> <p>Health and safety goals are established and regularly reviewed at the village managers monthly teleconference meeting. Risk management, hazard control and emergency policies and procedures are implemented and are monitored by the health and safety committee at the monthly health and safety meeting. Hazard identification forms and an up-to-date hazard register are in place. There is a falls prevention programme implemented (ink 1.3.6.1). Three of the village specific goals in the Mary Doyle Lifecare 2021 quality plan set annually in July each year relate to health and safety. The first goal is around pressure Injury reduction; the second relates to infection control and to the reduction of urinary tract infections with a target of <10% of total resident number per month; and the third being to reduce manual handling related staff injuries by 20%. All goals are currently progressing well with initiatives being implemented.</p>
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<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>	FA	<p>The service collects incident and accident data and manually collates this information for analysis. Monthly and annual reports are produced, which are then discussed at the staff meetings.</p> <p>There were 23 resident-related incident forms reviewed. All incident forms (one near miss, two episodes of challenging behaviour, two witnessed falls, fourteen unwitnessed falls and five classified as 'other') identified a timely RN assessment of the resident and corrective actions to minimise resident risk and reoccurrence. Neurological observations were not completed for all unwitnessed falls (link 1.3.6.1). The caregivers interviewed could discuss the incident reporting process. The care managers investigate and sign off on all incident reports.</p> <p>The care managers and national quality manager interviewed could describe situations that would require reporting to relevant authorities. Public Health were notified appropriately for two outbreaks occurring since the last audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	PA Low	<p>There are human resources policies in place, including recruitment, selection, orientation and staff training and development. Sixteen staff files sampled, (four caregivers, one kitchenhand, one cleaner, the kitchen manager, a diversional therapist, two care managers, acting village manager/clinical manager, four RNs and one enrolled nurse), included evidence of the recruitment process, employment contracts and reference checks. Job descriptions are on each file.</p> <p>The orientation programme provides new staff with relevant information for safe work practice and is developed specifically to worker type. Orientation is completed when staff come into the service with one new staff interviewed stating that the orientation programme had included a buddy system and review of policies. A training programme is in place with staff accessing an online programme to complete topics. Competencies are also completed. Staff have had extensive training around Covid-19, pandemic planning and use of personal protective equipment (PPE). Annual performance appraisals are not always completed annually. The service has a designated staff educator to support new and existing staff.</p> <p>A register of practising certificates is maintained with all health professionals having a current annual practicing certificate on file.</p> <p>There are three care managers and eighteen RNs. Thirteen RNs are identified as being interRAI trained.</p> <p>There are 122 caregivers in the service. Caregivers have completed the following Careerforce training as per contractual specifications: level 0 – 3; level 2 – 19; level 3 – 23; and level 4 – 43. Caregivers in the dementia unit have completed relevant NZQA dementia standards.</p>
<p>Standard 1.2.8: Service</p>	FA	<p>Human resources policies include documented rationale for determining staffing levels and skill mixes for safe service delivery. Sufficient staff are rostered on to manage the care requirements of the residents. The service</p>

<p>Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>has a total of 252 staff in various roles. These include a management team, 18 RNs, 7 enrolled nurses, 122 caregivers, 10 activities/diversional therapists, 7 administration staff, 76 support services staff.</p> <p>Staffing rosters were sighted and there is staff on duty to match needs of different shifts.</p> <p>The care managers (all RNs) are all rostered on as additional staff to the RNs identified above. The care managers provide an on-call service for staff should they need support. The care managers are aware that extra staff can be called on for increased resident requirements.</p> <p>There is a team leader (a level 4 caregiver) rostered onto the morning and afternoon shifts with an enrolled nurse rostered on the afternoon shifts for three days one week and five days the next week.</p> <p>The team leader (a level 4 caregiver) is rostered on the morning and afternoon shifts and this is included in the numbers above</p> <p>The service is divided across five separate units.</p> <p>In Ashcroft (dementia unit) with an occupancy of 32 residents, there are four caregivers in the morning (three on a long shift and one on a short shift); five in the afternoon (two long shift and three short shift); and two caregivers overnight.</p> <p>Goddard (dementia unit) with an occupancy of 30 residents, there are four caregivers in the morning (two on a long shift and two on a short shift); five in the afternoon (two long shift and three short shift); and two caregivers overnight. Across the two dementia units, there is a registered nurse working 32 hours a week and a second registered nurse identified as 40 hours a week.</p> <p>In Bramlee with an occupancy of 34 residents requiring rest home level of care, there are five caregivers in the morning (two on a long shift and three on a short shift); six in the afternoon (three long shift and three short shift); and one caregiver overnight. There is one registered nurse for eight hours, five days a week and one registered nurse for Saturday and Sunday every second week.</p> <p>Reeve with 30 hospital and six rest home residents, there are eight caregivers in the morning five on a long shift and three on a short shift); six in the afternoon (three long shift and three short shift); and two caregivers overnight. There is one registered nurse on each shift.</p> <p>Nimon with 17 hospital and five rest home residents, there are five caregivers in the morning (three on a long shift and two on a short shift); five in the afternoon (two long shift and three short shift); and one caregiver overnight. There is one registered nurse on each shift.</p> <p>There is a caregiver who works between both Nimon and Bramlee overnight.</p> <p>Three serviced apartments noting that these were not occupied on the day of audit. Three serviced apartments are certified to provide rest home level care for a resident occupying these, noting that these were not occupied on the day of audit.</p>
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		Interviews with staff, residents and family members confirmed there are sufficient staff to meet the needs of residents. The caregivers interviewed confirmed that they have sufficient staffing levels.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	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. Resident files are protected from unauthorised access by password protection for electronic files and information. Informed consent to display photographs is obtained from residents/family on admission. Other residents or members of the public cannot view sensitive resident information. Amendments to care plans were individually signed and dated with a designation recorded.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	There is an implemented organisational admission policy. All residents have a needs assessment completed prior to entry that identifies the level of care required. The acting village manager and three care managers screen all potential enquiries to ensure the service can meet the required level of care and specific needs of the resident. An information pack including all relevant aspects of the service, advocacy and health and disability information is given to residents/families/whānau at entry. Specific information around dementia care and secure environments was also included in the information pack. All relatives interviewed were familiar with the contents of the pack. The admission agreement provides information on services which are excluded, and examples of how services can be accessed that are not included in the agreement. Short-stay agreements are also available for short-stay residents; there were no short stay residents at the time of audit.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	The service has a policy that describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. The DHB 'yellow envelope' initiative is used to ensure the appropriate information is received on transfer to hospital and on discharge from hospital back to the facility. Communication with family is made. Care staff interviewed could accurately describe the procedure and documentation required for a resident transfer out of, and admission into the facility.

<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 are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were no residents self-medicating on the day of audit. There are no standing orders, and no vaccines are stored on site.</p> <p>The facility uses an electronic medication management and robotic pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. Registered nurses, enrolled nurses and medication competent, level 4 caregivers (team leaders) administer medications, have up to date medication competencies and there has been medication education in the last year. Registered nurses have syringe driver training completed by the hospice. The medication fridges and room temperatures are checked daily and are within the required ranges. Eye drops viewed in medication trolleys had been dated once opened.</p> <p>Staff sign for the administration of medications electronically. Twenty-six medication charts were reviewed. Medications are reviewed at least three-monthly by the GP. There was photo identification and allergy status recorded. 'As required' medications had indications for use charted and the effectiveness documented.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The kitchen manager oversees the procurement of the food and management of the kitchen. All meals are cooked on site, with meals being delivered to all six units in heated scan boxes. The kitchen was observed to be clean and well-organised, and a current approved food control plan was in evidence, expiring November 2021. All kitchen staff are qualified in food hygiene. Special equipment such as lipped plates is available. On the day of audit, meals were observed to be well presented.</p> <p>There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. There is a procedure and policy for kitchen fridge and freezer temperatures to be monitored and recorded daily. Food temperatures are checked at all meals. The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. This is reviewed six-monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen using a printed dietary profile from the electronic resident management system. Special diets and likes and dislikes are detailed on this dietary profile, a copy of which is kept by the kitchen for each resident. The caregivers take a weekly menu to each individual resident (rest home and hospital) enabling them to choose meals in advance if they wish to do so.</p> <p>The four-weekly seasonal menu is approved by an external dietitian.</p> <p>Residents and families interviewed expressed satisfaction with the meals. Additional snacks are available at all times.</p>
<p>Standard 1.3.2:</p>	<p>FA</p>	<p>The reason for declining service entry to potential residents should this occur, is communicated to the potential</p>

<p>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>		<p>resident or family/whānau and they are referred to the original referral agent for further information. The reasons for declining entry would be if the service had no beds available or could not provide the level of care.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. InterRAI assessments had been completed for all long-term residents' files reviewed. Six monthly interRAI assessments and reviews were evident for nine of thirteen resident files sampled as one hospital and two rest home residents and one dementia care resident had not been in the service for six months.</p> <p>Resident files reviewed identified that risk assessments are completed on admission and reviewed six-monthly as part of the evaluation unless changes occur prior, in which case a review is carried out at that time. Additional assessments for management of behaviour, pain, wound care, nutrition, falls and other safety assessments including restraint, were appropriately completed according to need. Behaviour, mood, and cognition assessments had been completed in all five dementia care files reviewed. For the rest home and hospital resident files reviewed, not all outcomes from assessments were reflected into care plans (link 1.3.6.1).</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>The RNs complete assessments to identify the care needs of the resident and use this information to inform the development of the care plan. Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans reviewed were resident-centred. Interventions documented support needs and provided detail to guide care with the exception of one hospital care plan (link 1.3.6.1). Behaviour management plans in the five dementia files reviewed reflected the outcomes of behaviour assessments. Residents and relatives interviewed stated that they were involved in the care planning process. There was evidence of service integration with documented input from a range of specialist care professionals, including the diabetic specialist nurse, dietitian, wound care specialist, occupational therapist, and mental health services for the older person. The care staff interviewed advised that the care plans were easy to follow. Integration of records and monitoring documents occurs. Long term care plans are updated for acute changes in health.</p>

<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Low</p>	<p>When a resident's condition changes, the RN will initiate a GP/NP consultation. Staff stated that they notify family members about any changes in their relative's health status. Care plans have been updated as residents' needs changed.</p> <p>Care staff stated there are adequate clinical supplies and equipment provided, including continence and wound care supplies and these were sighted.</p> <p>Nutrition has been considered, with fluid and fluid monitoring, regular weight monitoring and weight management implemented where weight loss was noted. The kitchen staff were aware of resident's dietary requirements and these could be seen documented and were easily accessible for staff in the kitchen. Interventions are documented in order to guide the care staff. Care staff interviewed, stated that they found these very helpful.</p> <p>Wound assessment, wound management and evaluation forms are in place for all wounds. Wound monitoring occurred as planned and there are also photos to show wound progress. Wounds included five chronic skin conditions, thirty-four skin tears, six abrasions, four cancerous lesions, seven moisture lesions, one laceration, one burn and eleven classed as 'other' which includes ingrown toenails, blisters etc. There is also one facility acquired grade 2 pressure injury and one grade one facility acquired pressure injury. There was evidence of wound nurse specialist involvement in chronic wound and pressure injury management.</p> <p>Monitoring forms are in use as applicable, such as weight, vital signs and wounds and neurological observations. However, monitoring was not always fully documented as required by the care plan. Behaviour charts for new or escalating behaviours were sighted in the files of dementia care residents. De-escalation strategies included re-orientation, re-direction, providing quiet time, activities, delirium screening and 'as required' medication as a last resort.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>CI</p>	<p>The service employs a Wellness Leader and seven activity assistants to develop and coordinate the activity programme. There are two qualified diversional therapists (DT) and five activity assistants working through their DT qualifications. There is an activity assistant based in each household (unit) from 9 am-4.30 pm. Caregivers are encouraged to involve themselves in activities with the residents. There are volunteers involved in pet therapy, men's workshop, crafts, storytelling and "Friends of the Apartments" for group facilitation, companionship and pamper services and bowls. The recreational programme incorporates the Arvida living well model – engaging well, thinking well, moving well, resting well, thinking well, and eating well. Each unit has its own programme that meets the physical, intellectual, cognitive, and emotional needs of the group of residents. Activities include (but are not limited to); arts, crafts, news and views, exercises, walking groups, baking, music, music appreciation, story time, reminiscence, walks, board games, indoor games, pampering sessions, gardening, movies, armchair travel, chat room, gardening, ballroom dancing and happy hour. There are many clubs such as coffee club, walking group, friendship club and men's club. The men's club for the men in dementia care has provided the men with meaningful and purposeful projects. Residents are involved in meaningful</p>

		<p>household activities. Some activities are integrated for all levels of care residents. One on one time is spent with residents who choose not to or unable to participate in group activities.</p> <p>There are two van outings/scenic drives a week. At least one staff member on the outings holds a first aid certificate. Festive occasions and theme days are celebrated.</p> <p>Community visitors include pet therapy, churches, entertainers, and high school Gateway students. There are five pilot drivers trained in taking residents for trishaw rides. Each rest home/hospital unit has a resident meeting. A “resident voice” meeting has been initiated for dementia care residents which has been successful.</p> <p>An “About Me” and a life history is completed soon after admission in consultation with resident and/or family to identify past hobbies, interests, occupation, family, spiritual and cultural supports. Individual recreational preferences are identified for all residents including those younger people under long-term chronic health condition contact. A leisure care plan is developed and evaluated six-monthly at the same time as the long-term care plan.</p> <p>The service receives feedback and suggestions for the programme through resident meetings and surveys. Residents and relatives interviewed expressed a satisfaction in the activities offered and felt there was always some activity to attend of their choice.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Long term care plans are evaluated by the RNs six monthly or earlier if there was a change in resident health status. Evaluations are documented and identify progress to meeting goals. A six-monthly care plan review is also completed by the registered nurse with input from caregivers, the GP, NP, the wellness leader, resident (if appropriate) and family/whānau members and any other relevant person involved in the care of the resident. Care plan interventions are updated as necessary as a result of the evaluation. Activities plans are in place for each of the residents and these are also evaluated six-monthly. There are three-monthly reviews by the GP for all residents, which family are able to attend if they wish to do so. Long term care plans are updated for acute changes in health.</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</p>	<p>FA</p>	<p>Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The registered nurse interviewed could describe the procedure for when a resident’s condition changes and the resident needs specialist input (i.e., hospice). Discussion with the care manager and registered nurse identified that the service has access to a wide range of support either through the GP, specialists, mental health services and allied health services as required.</p>

<p>providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>		
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>There are policies and procedures in place for the safe storage and use of chemicals. Chemicals are stored safely within the sluice room of each unit. The main chemical cupboard is within the main laundry. Chemicals are labelled correctly. Safety data sheets are available. Chemical spills kits are available. Personal protective equipment is available at the point of use. Staff were observed to be wearing appropriate protective clothing. All relevant staff have completed chemical safety training.</p> <p>There are policies and procedures in place for the management of waste. All waste was disposed of appropriately. Approved sharps containers were in place for the safe disposal of sharps.</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>Mary Doyle Lifecare includes Bramlee and Nimon units which are in one building on the grounds. The other building includes Reeve hospital unit and Goddard and Ashcroft, (two dementia care units). Both buildings have current building warrants of fitness certificates which expire 19 June 2021. Building checks were underway for building warrant of fitness renewal. The maintenance manager (full-time and on call) oversees the maintenance and grounds team, two porters and contractors. There is a maintenance book in each nurses' station which is checked daily, issues addressed and signed off as completed. There are essential contractors available as required. There is an annual maintenance schedule that include water temperature monitoring, electrical testing and tagging and calibration/checks of clinical equipment. Hot water temperatures in resident areas had been maintained below 45 degrees Celsius. Planned maintenance reports are forward to the property manager at support office.</p> <p>The corridors are wide and allow for safe mobility with the use of mobility aids and lazy boy chairs in the rest home and hospital units. There was safe access (including wheelchair access) to the outdoor courtyards, seating, and shade.</p> <p>The two dementia units have many exit/entry doors to the large secure outdoor courtyards and walking pathways. There are raised gardens, seating, and shade and a clothes line. One courtyard has bird aviaries, and the other courtyard has the outdoor seating shed and tool shed. Residents were observed to be walking in the courtyards independently and under supervision. The respite room in Goddard dementia unit was assessed as suitable for</p>

		<p>respite care. There is an external window, heating, and call bell.</p> <p>Care staff interviewed stated they had adequate equipment in each unit to safely carry out cares as per the care plans. There is adequate space in the facilities for storage of mobility/transferring equipment.</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>The Bramley (rest home) and Reeve (hospital) unit bedrooms have ensuites. There are two standard rooms in Nimon with toilet and shower located nearby with all other rooms having an ensuite. There is a large bathroom which can accommodate a shower trolley if required. All bedrooms in Ashcroft dementia care unit have ensuites. All bedrooms in Goddard dementia care unit have ensuites with the exception of the respite room. A separate toilet and shower are located across the corridor from the room. Handrails are appropriately placed in ensuite bathrooms and communal showers and toilets. Privacy is assured with the use privacy curtains and privacy locks on communal toilet/shower rooms.</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>Bedrooms in all the units are single, spacious, and of an adequate size appropriate to the level of care provided. The rest home rooms allow for the resident to move about the room independently with the use of mobility aids. The hospital level rooms allow for the easy manoeuvre of hoists, lazy boy chairs and other equipment required to safely deliver care. The bedrooms in the dementia units have sufficient space for residents to move about safely with mobility aids if required. Residents and their families are encouraged to personalise the bedrooms as viewed on the day of audit.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe,</p>	FA	<p>The Bramlee unit has seating and a shared library near the reception area. Bramlee and Nimon units have large lounge and dining areas. Seating is placed appropriately to allow for group and individual activities to occur. Reeve hospital unit communal areas are spacious enough provide an additional area for activities with two lounges available.</p> <p>Each dementia care unit has a large spacious dining room with brightly decorated walls. There is a lounge at</p>

<p>adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>		<p>each end of the units that opens out into the courtyard.</p> <p>All the corridors in both buildings are wide with appropriately placed handrails. Residents have easy access to communal areas for relaxation, dining, and activities and outdoors.</p> <p>Each building has a hairdresser's room. The Riverstone café between the two buildings is available for residents and families during the day and can be booked for special functions.</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>The main laundry which is located in the main building (Reeve, Goddard, and Ashcroft) has separate rooms for the washing and drying of laundry, personal clothing and laundry. The laundry operates from 7 am to 4 pm. There is a defined clean dirty/area with two entry/exit doors. Porters transport from the other building in covered bins on wheels. There is a separate clean linen room for folding and ironing. Laundry staff have complete relevant training including infection control. There is a laundry area in the Bramlee/Nimon building where personal clothing is laundered by a designated laundry person. There is a small laundry in one of the dementia care units where caregivers launder personal clothing only.</p> <p>There are designated cleaners for each unit from 9 am to 2 pm. Cleaners' trolleys viewed were well equipped and adequate personal protective equipment was available. Cleaning trolleys are locked away when not in use. Product wall charts and safety data sheets are available in cleaning and laundry areas. Internal audits are carried out on laundry and cleaning processes. Staff have completed chemical safety training.</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>Emergency management plans are in place to ensure health, civil defence and other emergencies are included. The facility is well prepared for emergencies and has civil defence kits (readily accessible in each of the units) and emergency lighting. All staff receive a site induction and ongoing education around responding to emergencies. The service has an evacuation scheme (396E024009) approved by the fire service. There are six-monthly fire drills held, last in February 2021, in all units. There is a first aid trained staff member on every shift at both buildings.</p> <p>Each unit has civil defence supplies. There is electric and gas cooking in the kitchen and barbeques are available for alternative cooking. At least three days of food is available including food store in both buildings and the café. There is a 30,000-litre external water tank. The facility is on a priority list for the hire of a generator.</p> <p>Pandemic planning is done in coordination with Hawkes Bay DHB and Arvida Group. Mary Doyle strictly follows Alert Level guidelines set by the Ministry of Health. A communication letter addressed to residents and family members would be sent immediately to notify of any Alert level change including the restrictions involved. Contact tracing procedures are also consistently in place, both QR code and written, in addition to staff and visitor declaration forms. The care centre managers and infection control coordinator report positive cases to the DHB Outbreak team and Arvida for further management and additional support. Some RNs are also trained with Covid</p>

		<p>swabbing.</p> <p>The call bell system is available in all bedrooms, ensuites and communal areas. Pendant call bells are worn by residents at risk.</p> <p>The buildings are secure at night. A security company conducts regular night rounds.</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 bedrooms and communal rooms have large windows allowing adequate natural light. Doors open out onto courtyards from some of the lounges and windows can be opened safely to allow adequate ventilation. The communal areas, corridors and bedrooms are heated appropriately and maintained at a comfortable temperature. There are individually temperature-controlled heaters in resident rooms. Residents interviewed confirmed that the environment is warm and comfortable.</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>Mary Doyle has an established infection control (IC) programme that is implemented. The acting village manager (registered nurse) is the infection control coordinator with support from the clinical team, care managers, national quality manager and general manager of wellness. The acting village manager has had previous experience as an infection control coordinator. There are defined infection control responsibilities in the job description for the infection control coordinator and terms of reference for the infection control committee. The infection control programme for Mary Doyle has been reviewed by the committee and in consultation with the relevant personnel.</p> <p>Visitors are asked not to visit if they are unwell. Residents and relatives interviewed stated they were kept well informed on visiting restrictions during the lockdown period. Covid screening for visitors and contractors continues. Influenza vaccines are offered to residents and staff. Alcohol gel is freely available throughout the facility.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate</p>	FA	<p>There are adequate resources to implement the infection control programme at Mary Doyle. The infection control (IC) coordinator has maintained practice by attending infection control meetings three monthly at the DHB and through monthly infection control meetings with the Arvida steering group for all infection control coordinators. The infection control team meets monthly and has representatives from across the services. External resources and support are available when required from the DHB, expertise as support office, public health, GPs, and</p>

<p>human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>		<p>laboratory services. Laboratory results are emailed to the RNs.</p> <p>Each unit has a supply of personal protective equipment which is checked weekly. A DHB representative completed a site visit to assess the facility preparedness in the event of a pandemic. The DHB and Arvida provided sufficient supplies of personal protective equipment. PPE is checked monthly and reported to Arvida to ensure that supplies are sufficient.</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>	<p>FA</p>	<p>The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes roles, responsibilities, procedures, the infection control team and training and education of staff. There is a dedicated Covid folder (on the intranet) including DHB and MOH guidelines. Information is printed off for staff into a resource folder. Arvida infection control policies are reviewed two yearly or earlier if required. Reviewed/new policies are discussed at unit meetings.</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>	<p>FA</p>	<p>Infection control education is included in the annual education planner. There has been additional education and training around outbreak management and Covid in an aged care environment. All staff complete infection control education on induction and ongoing around hand hygiene – competencies and questionnaires. Altura modules on infection control are completed by all staff. Some staff have been trained in Covid swabbing.</p> <p>Information is discussed with residents that are appropriate to their needs including hand hygiene.</p>
<p>Standard 3.5:</p>	<p>FA</p>	<p>Infection surveillance is an integral part of the infection control programme and is described in the Arvida group</p>

<p>Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>infection control manual. Monthly infection data is collected for all infections based on standard definition of signs and symptoms of infections. Surveillance of all infections is entered into the monthly online infection control register. The infection control coordinator/RN collates data which is analysed for trends and opportunities for improvements. Analysis of infections and corrective actions are discussed at the combined infection control/health and safety committee meetings and is an agenda topic across all facility meetings. Data and graphs are made available to all staff. Benchmarking occurs within the Arvida group.</p> <p>There have been two outbreaks since the last audit. One scabies outbreak in Reeve (dual-purpose beds) in August 2019 and one norovirus outbreak in the dementia care unit's March 2020. The outbreaks were contained and well managed. Case logs, correspondence and DHB/public health notifications were sighted.</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 policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.2. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. Interviews with the staff confirmed their understanding of restraints and enablers.</p> <p>At the time of the audit, the service had three hospital level residents using bed rails as a restraint, one hospital resident with bed rails and chair brief as restraints, one hospital resident with chair brief only (restraint), one rest home resident using bedrails as a restraint and five hospital level residents using bedrails as an enabler.</p> <p>Staff training is available around restraint minimisation and management of challenging behaviours, indications for restraint use, consent process, duration of restraint and monitoring requirements.</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 (care manager) are documented and understood. The care manager has a sound understanding of the restraint minimisation programme.</p> <p>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. Suitably qualified and skilled staff, in partnership with the resident and their family/whānau, undertake assessments. Restraint assessments are based on information in the care plan, resident discussions and on observations of the staff. Ongoing consultation with the resident and family/whānau are evident. The files for three hospital level residents using bed rails as a restraint, one hospital resident with bed rails and chair brief, one hospital resident with chair brief, one rest home resident using bedrails as a restraint and five hospital level residents using bedrails as an enabler were reviewed. The completed assessments 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>The restraint approval process includes ensuring the environment is appropriate and safe. Assessments and care plans identify specific interventions or strategies to trial (as appropriate) before restraint is used.</p> <p>The care plans reviewed of six residents with restraint, identified observations and monitoring with monitoring records indicating it is occurring at the frequency determined in the restraint assessment.</p> <p>Restraint use is reviewed through the three-monthly evaluation process and six-monthly multidisciplinary meetings. Restraint use is also discussed monthly at quality meetings. A restraint register is in place, providing a record of restraint use and is completed for 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). Evaluation has occurred at least three-monthly as part of the ongoing reassessment for the residents on the restraint register. Evaluation timeframes are determined by risk levels.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>The restraint programme, including reviewing policies and procedures and staff education, is evaluated annually at Arvida support office.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.1.10.7 Advance directives that are made available to service providers are acted on where valid.	PA Low	Advanced directive forms include hospital admission, active treatments, and resuscitation status. There is a separate resuscitation form completed by the GP for residents who lack the competency to make a decision. Advance directives reviewed in the eight-rest home/hospital files had been signed appropriately, however advance directives had been incorrectly signed for three of five dementia care resident files reviewed.	The resuscitation status (in the advance directive form) had been authorised by the relative (two written and one verbal – documented in progress notes) for three of the five dementia care files reviewed.	Ensure the resuscitation status section of the advance directive form is appropriately signed. 180 days
Criterion 1.2.3.8 A corrective action plan addressing areas	PA Low	There is a documented process to record corrective actions when these are identified. In 2020, there was limited completion of audits. Audits are now being completed as per schedule and clinical indicators are monitored, however corrective actions are not always identified when issues are raised. The number of urinary tract infections increased between February and May 2021 for example, however a corrective action plan was not documented.	i) Corrective action plans are not usually documented when issues are raised in audits or in meetings. ii) There is limited	i) Ensure that corrective action plans are documented when issues are raised.

requiring improvement in order to meet the specified Standard or requirements is developed and implemented.		Pressure injuries were recorded with a corrective action plan documented by the acting village manager, however there was no record of monitoring of progress. Skin tears increased; however a corrective action plan was not documented. There was limited evidence of resolution of issues documented when issues were identified in meeting minutes.	evidence of resolution of issues when raised (e.g., in meeting minutes).	ii) Ensure that there is resolution of issues documented (e.g., in meeting minutes) when issues are raised. 90 days
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.	PA Low	There is a documented process for completion of performance appraisals. Twelve of the sixteen staff records reviewed showed evidence that a performance appraisal had been completed annually.	Four of 16 staff files did not include a current annual performance appraisal.	Ensure that performance appraisals are completed annually as per policy. 180 days
Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to,	PA Low	Interviews with the care manager and registered nurses demonstrated an understanding of the assessment, monitoring, and management plans. Monitoring forms are used to monitor residents' health and well-being including blood pressure and pulse, weight, blood sugar levels, behaviour, repositioning, food, and fluid intake/output. However, monitoring was not always fully documented as required by the care plan. Long term care plans are updated for acute changes in health such as wounds, skin tears and infections. These had been reviewed regularly and closed off when resolved.	(i). Nineteen incident forms were sampled where the resident had experienced an unwitnessed fall. RN assessment was documented following the incident however, neurological observations were not	(i)- (iii). Ensure resident monitoring charts are consistently and comprehensively completed as per policy and/or as detailed in their care plan. (v).

<p>meeting the consumers' assessed needs, and desired outcomes.</p>			<p>completed as per policy for eight falls and only partially completed for nine falls.</p> <p>(ii). One hospital resident with a catheter did not have four hourly output monitoring as detailed in the care plan completed consistently.</p> <p>(iii). One hospital resident did not have vital sign observations taken every 48 hours as ordered by the general practitioner and detailed in the care plan.</p> <p>(iv). One hospital resident file sampled did not include documented interventions in sufficient detail to guide the care staff in the management of psychosis and triggers for deteriorating mental health.</p>	<p>Ensure interventions clearly cover all assessed needs.</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
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	CI	<p>The service identified residents with dementia have opinions and a right to a “voice” thus empowering them to participate in social engagement, friendships, resident led activities, meaningful</p>	<p>Resident meetings are held in the rest home and hospital households, however there was no meeting group for dementia are residents, so a project was established.</p> <p>i) The wellness leader and activity assistant in DT training who are based in the two dementia care units trialled “resident voice” meetings through 2019-2020 which were disrupted due to Covid and have since recommenced. Initially “resident voice” meetings were held twice a week as this enabled a ritual of frequency for residents with memory loss and providing comfort in repetition. The meeting environment was important to ensure residents felt comfortable. A table setting, and whiteboard was used as it provided a psychological “safety” of a barrier and helped decrease feelings of vulnerability with an open space, also the familiar memory of being on a board, committee or office worker encouraged residents to join in. A whiteboard with a written topic was used as a visual prompt and to record responses, suggestions, and ideas, empowering them to see their comments being recognised and “seen”. Photos and images were introduced on the whiteboard to support residents who were challenged with reading and written words. Photos of whiteboard meetings are posted for reading by residents (as appropriate), staff and family. Familiar rituals were created at the beginning and end of the meetings such as shaking hands and individual greeting by name at the beginning of the meeting and the end by shaking hands and thanking by name (providing a recognised structure) and finishing with an afternoon tea. Initially a few residents would join the meeting or stop and sit for a while. As</p>

		<p>and purposeful activities. Resident meetings are held in the rest home and hospital households, however there was no meeting group for dementia care residents.</p> <p>The “resident voice” meetings were initiated, and the men’s group were involved in meaningful projects. Both initiatives have been successful and align with the Arvida philosophy of choices and decisions for everyday life.</p>	<p>weeks went by more residents started joining in, sitting, and focusing for longer periods and contributing and sharing in conversations. The wellness leaders noticed friendships forming between residents, more conversation and connection between them. Staff, family, and visitors were invited to join in. Residents would ask “when the next meeting was” and automatically gather near to the time of the meeting. The impact/outcome of introducing a “residents voice” meeting has had overwhelming positive effects including more meaningful relationships (resident to resident, resident to staff and vice versa), residents’ opinions, wants and requests being heard and actioned, promoting autonomy and choice, residents leading more purposeful daily activities, increasing feelings of belonging, pride, empowerment, importance and remaining engaged in their household. Photos of whiteboard discussions and meeting attendance and environment were sighted.</p> <p>ii) There is a designated men’s club for the dementia units based in Goddard unit. The men’s club is held weekly and coordinated by the Restorative therapist/wellness leader and a volunteer carpenter. The attendance varies (at least eight men) and includes men from the Ashcroft unit. Activities are related to past interests and activities and include outings and building projects. Projects are meaningful and have a purpose and have included painting concrete pots for the gardens, making a bench seat for the courtyard, de-mossing chairs, putting together the kitset tool shed, refurbishment of beside tables for use in other units, built the café sign for the Riverstone café. The men contribute to the three-monthly facility theme by making decorations such as for the French day the men built the Eiffel Tower that was displayed. The men have made items for raffles such as tool boxes and towel rails (designed by resident). These weekly workshops give the men a sense of purpose and achievement. The men’s club now begins with a self-service morning tea with the men finishing with doing the dishes. Photo albums of the men’s club were viewed.</p>
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End of the report.