

Mary Doyle Healthcare Limited

Introduction

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

The audit has been conducted by Health Audit (NZ) 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: 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)

Dates of audit: Start date: 10 February 2015 End date: 11 February 2015

Proposed changes to current services (if any): Mary Doyle provides dementia level care beds. No changes to current services.

Total beds occupied across all premises included in the audit on the first day of the audit: 148

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
	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
	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 Lifecare provides hospital, rest home and dementia level care for up to 161 residents and on day one of the audit there were 148 residents. The service is operated by Mary Doyle Healthcare Limited and is managed by a general manager. The residents and relatives interviewed were very complimentary about the service provided.

This unannounced surveillance audit has been undertaken to establish compliance with specified parts of the Health and Disability Services Standard and the District Health Board contract. 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.

The three areas identified as requiring improvement during the last audit relating to the use of short term care plans, aspects of medication management and storage of chemicals have been addressed. No areas were identified as requiring improvement during this audit.

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.
------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	------------------------------------------------------

Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), including the facility's complaints process and the Nationwide Health and Disability Advocacy Service, was accessible and is brought to the attention of residents' (if able) and their families on admission to the facility. Residents and family members interviewed confirmed that their rights were met during service delivery that staff were respectful of their needs and communication was appropriate.

The general manager is responsible for management of complaints and a complaints register is maintained.

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.
-----------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	------------------------------------------------------

Mary Doyle Healthcare Limited is the governing body and is responsible for the service provided at Mary Doyle Lifecare. A management company, Hurst Lifecare, is contracted to provide support to the governing body and facility. Planning documents reviewed included a quality management plan, a business plan, a mission statement, values, and philosophy.

The general manager (GM), who is a registered nurse, is a very experienced manager and is responsible for the overall management of the complex. The general manager is supported by an assistant manager and four care managers. The care managers are responsible for oversight of the clinical care provided in their respective units. Registered nurse cover is provided 24 hours a day, seven days a week.

There was evidence that quality improvement data has been collected, collated, and analysed to identify trends and improve service delivery and that this information has been reported to staff. There is an internal audit programme in place and internal audits have been completed. Corrective action plans have been developed to address areas identified as requiring improvement. Risks have been identified and the hazard register is up to date. Adverse events are documented on accident/incident forms.

There are policies and procedures on human resources management and the validation of current annual practising certificates for health professionals who required them to practice has occurred. A registered nurse is employed to manage the inservice education programme and in-service education has been provided for staff on a regular basis. Staff are also supported to complete the New Zealand Qualifications Authority Unit Standards relating to aged care and dementia care. Staff records reviewed provided evidence human resources processes have been followed and individual education records have been maintained.

A documented rationale for determining staffing levels and skill mix was reviewed. The minimum number of staff on duty at any one time is two registered nurses and 10 care givers. Care staff interviewed reported there is adequate staff available and that they are able to get through their work.

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.		Standards applicable to this service fully attained.
--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	------------------------------------------------------

Residents received services from suitably qualified and experienced staff. Evaluations were documented, resident-focused and indicated progress towards meeting the desired outcomes. Where the progress of a resident was different from the expected, the service responded by initiating changes to the lifestyle care plan. Family had opportunity to contribute to care plans.

Residents had initial care plans, short term care plans for acute conditions and lifestyle care plans for long term service delivery. Resident, nursing and medical reviews were conducted within the required timeframes. Activities were planned and the programme provided to residents and family.

The medicines management system provided safe processes for prescribing, dispensing, review, storage, disposal of medicines. Medicine management training was conducted annually. The medicines policy included a section on the self-administration of medicines. There were three residents self-administering medicines. The service had a process for reviewing the resident's competency to self-administer their medicines and monitored the residents according to the requirements of the medicines

management guidelines. Service providers responsible for medicines management completed annual competencies. Medicines charts were legible, allergies were identified and controlled drug register entries were in line with legislative requirements. Medicines fridge temperatures were maintained and recorded.

Food and nutritional needs of residents were provided in line with recognised nutritional guidelines appropriate to the needs of the residents. Menus were reviewed annually. The cook received a duplicate of the dietary plan for new residents to ensure dietary needs of the residents were implemented. Kitchen staff completed food safety training.

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.

All resident bedrooms provide single accommodation, are personalised, have wash hand basins and ensuite facilities. Residents' rooms were large and adequate personal space is provided in bedrooms.

Lounges, dining areas and various other alcoves are available for residents in both buildings. Several external areas are available for sitting and shading was provided. An appropriate call bell system is available and security systems are in place.

Inspection provided evidence of sluice facilities, safe storage of chemicals, soiled linen and equipment. Protective equipment and clothing was provided and used by staff. Documentation reviewed confirmed appropriate systems are in place to ensure the residents' physical environment is safe and facilities are fit for their purpose.

Policies and procedures for waste management, cleaning and laundry, and emergency management are available and these were known by staff. All laundry is washed on site and cleaning and laundry systems included appropriate monitoring systems are in place to evaluate the effectiveness of these services.

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.
---------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	------------------------------------------------------

Documentation of restraint minimisation and safe practice policies and procedures, and their implementation, demonstrated restraints and enablers that were least restrictive. There were 26 resident using bedrails and lap restraints and 11 resident who used enablers in the form of bedrails.

Systems were in place to ensure assessment of residents is undertaken prior to enabler or restraint use being implemented. The resident's files demonstrated enabler and restraint assessments, risk assessments and monitoring processes were implemented and followed. Enablers and restraints were recorded in the restraint register.

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.
-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	------------------------------------------------------

Surveillance was appropriate to the size and complexity of the organisation.

Documentation provided evidence that the service had surveillance reporting processes in place. Surveillance results were reported in each area of service. The care managers collated information at monthly intervals and data was recorded as clinical quality indicators on their system.

Quality indicators were reported at health and safety, quality, registered nurses and staff meetings. The data was collated and displayed in clinical areas. Staff had access to surveillance information, Infection control education was provided annually as part of the in-service education programme. Staff members completed annual infection control competencies.

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	17	0	0	0	0	0
Criteria	0	43	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	<p>The general manager is overall responsible for management of complaints and there were appropriate systems in place to manage the complaints processes. A complaints register was maintained that included verbal and written complaints.</p> <p>The general manager advised there have been no complaint investigations by the Ministry of Health, District Health Board (DHB), Accident Compensation Corporation (ACC) or Coroner since the previous audit at this facility. They also advised there has been one police investigation and the staff member involved is no longer working at Mary Doyle Lifecare. There has also been one Health and Disability Commissioner investigation and a letter dated 16 January 2014 was reviewed from the Health and Disability Commissioner advising "I have made a decision ... to take no further action on this complaint."</p> <p>Complaints policies and procedures are compliant with Right 10 of the Code. Systems are in place to ensure residents and their family are advised on entry to the facility of the complaint processes and the Code. Residents and family demonstrated an understanding and awareness of these processes. Resident meetings are held two monthly in the rest home and residents are able to raise any issues they have during these meetings. This was confirmed during interview of residents and family and review of resident meeting minutes.</p> <p>Observations of the facility provided evidence that the complaint process was readily accessible and/or displayed. Quality meeting minutes and the general manager's monthly reports to the chief executive officer (CEO) provided evidence of reporting of complaints to the governing body. Care staff confirmed this</p>

		information is reported to them via their unit staff meetings and this was confirmed during review of meeting minutes.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	<p>An open disclosure policy and procedure was in place to ensure staff maintain open, transparent communication with residents and their families. Residents' files provided evidence that communication with family members was being documented in residents' records. There was evidence of communication with the GP and family following adverse events, which was recorded on the accident/incident forms and in the individual resident's files. Residents and family confirmed that staff communicate well with them. Residents confirmed that they are aware of the staff that are responsible for their care.</p> <p>The general manager and one of the care managers advised access to interpreter services is available if required via the local community and District Health Board. They also advised there is currently one resident who requires interpreter services.</p> <p>The residents and family are informed of the scope of services and any items they have to pay that is not covered by the agreement. Admission agreements were reviewed and this was clearly communicated in each agreement.</p>
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	<p>Mary Doyle Healthcare Limited is the governing body and is responsible for the service provided at Mary Doyle Lifecare. A management company, Hurst Lifecare, is contracted to support to the governing body and facility. The national quality advisor from the management company was interviewed during this audit.</p> <p>A business plan and a quality and risk management plan included a purpose, scope, direction, goals and objectives. A mission statement, values, vision and objectives are available. The service philosophy is in an understandable form and is available to residents and their family / representative or other services involved in referring residents to the service.</p> <p>The general manager (GM), who is a registered nurse, is responsible for the overall management of the facility. The GM is supported by an assistant manager (AM) and four care managers (CMs). The CMs are responsible for oversight of the clinical care provided in their respective units. Registered nurse cover is provided 24 hours a day, seven days a week. The GM, who was appointed to their current position in 2001, is a very experienced manager who has worked in health care management positions for the last 21 years.</p> <p>The personnel files and annual practising certificates for the GM, AM, CMs and some of the RN's were reviewed and are current. There was evidence on the GM's, AM's, CM's and RN's files of ongoing education.</p> <p>The GM provides monthly reports to the Chief Executive Officer (CEO). The GM also provides monthly and quarterly reports to the national quality advisor with quality improvement data for benchmarking against other</p>

		<p>facilities Hurst Lifecare is contracted to manage.</p> <p>Mary Doyle Lifecare is currently certified to provide 34 rest home level beds, 64 dementia level beds and 63 hospital level beds. There were 34 residents assessed as requiring rest home level care, 55 assessed as requiring dementia level care and 59 assessed as requiring hospital level during this audit. There are 10 dual purpose beds that are able to be used for either rest home or hospital level care residents.</p> <p>The service provider has contracts with the District Health Board (DHB) to provide aged related residential care (rest home), day care and residential respite services - rehabilitation and support services.</p>
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	<p>A business plan and quality and risk management plan are used to guide the quality programme and include goals and objectives</p> <p>An internal audit programme is in place and completed internal audits for 2014 were reviewed, along with processes for identification of risks. Risks were identified, and there is a hazard register that identifies health and safety risks as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk. A Health and Safety manual was available that included relevant policies and procedures.</p> <p>Documented values, mission statement and philosophy are available. Monthly quality meetings are held as are monthly staff meetings in each of the five units.</p> <p>Two monthly rest home resident meetings are held. Meeting minutes are available for review by staff in each area. Meeting minutes provided evidence of reporting / feedback on completion of internal audits and various clinical indicators. Meeting minutes for 2014 and 2015 were reviewed.</p> <p>The four care managers (CM) provide monthly reports to the general manager (GM) and a sample of these were reviewed. The general manager (GM) provides monthly reports to the chief executive officer (CEO) and a sample was reviewed and included reporting on occupancy, staffing and human resource management, environmental and property reports, financial reporting and general comments. The GM and assistant manager (AM) are responsible for ensuring the organisations quality and risk management systems are maintained.</p> <p>Clinical indicators and quality improvement data is recorded on various registers and forms and were reviewed as part of this audit. There was documented evidence quality improvement data is being collected, collated, analysed and evaluated: including reporting on numbers of various clinical indicators and quality and risk issues to staff. Meeting minutes and reports reviewed also provided evidence of discussion of any trends identified, as well as reporting on infection control and health and safety. Staff interviewed reported they are kept very well informed of quality and risk management issues including clinical indicators. Quality improvement data reviewed, including adverse event forms, internal audits and meeting minutes provided evidence that corrective action plans are being developed, implemented, monitored and signed off as being completed.</p>

		<p>Copies of meeting minutes and clinical indicators are available in the staff offices for staff to review. Adverse events were documented on accident/incident forms and copies of these are retained in the resident's files.</p> <p>Relevant standards were identified and included in the policies and procedures manuals. Policies and procedures were reviewed that are relevant to the scope and complexity of the service, reflects current accepted good practice, and reference legislative requirements. Policies / procedures were available with systems in place for reviewing and updating the policies and procedures regularly including a policy for document update reviews and document control policy. The national quality advisor reported they are currently reviewing all policies and forms used by the Hurst Lifecare group. Staff confirmed during interviews that they are advised of updated policies and they confirmed the policies and procedures provide appropriate guidance for the service delivery.</p> <p>A Health and Safety Manual was available that included relevant policies and procedures and there was a hazard reporting system available as well as a hazard register. Chemical Safety data sheets were available that identify the potential risks for each area of service. Planned maintenance and calibration programmes were in place and were reviewed. All biomedical equipment had appropriate performance verified stickers in place. Electrical safety stickers were observed in place.</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>	FA	<p>Staff were documenting adverse, unplanned or untoward events on an accident/incident form. There is at least one registered nurse (RN) in each of the two buildings 24 hours a day and the RN is advised of all adverse events if there is an injury to a resident. The RN assesses all residents if there is an injury. Neurological observations are undertaken of residents if there is any head injury or potential head injury. All accident and incident forms are reviewed by the RN and the CM for each unit. The RN is responsible for investigating the event as well as for documenting any corrective actions required.</p> <p>Resident files provided documented evidence of communication with family and GP on the accident/incident form and in resident progress notes. There was also evidence during this audit of notification to family of any change in the resident's condition. This finding was confirmed during interviews of residents and family members. There is an open disclosure policy.</p> <p>Corrective action plans to address areas requiring improvement were documented on accident/incident form and there was evidence of monitoring of this.</p> <p>Staff confirmed that they are made aware of their responsibilities for completion of adverse events through: job descriptions; policies and procedures; and staff education, which was confirmed via review of documentation. Staff also confirmed they are completing accident / incident forms for adverse events. Policy and Procedures comply with essential notification reporting (e.g. health and safety, human resources, infection control).</p>

<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>A registered nurse (RN) is employed for 30 hours a week to oversee the inservice education programme. The RN educator is also a qualified first aid instructor and Aged Care Education (ACE) Assessor. Staff are required to complete the New Zealand Qualifications Authority approved aged care education modules as well as first aid training. All staff are required to complete the dementia specific modules and all staff working in the dementia units have either completed or commenced the dementia specific modules. Staff are also supported to complete education via external education providers.</p> <p>There was comprehensive evidence available indicating in-service education is provided for staff on a regular basis. The education records for 2014 and 2015, individual staff attendance records and attendance records for each education session provided evidence ongoing education is provided. Competency assessment questionnaires were available and completed competencies were reviewed.</p> <p>Written policies and procedures in relation to human resource management were available. The skills and knowledge required for each position within the service is documented in job descriptions which outline accountability, responsibilities and authority which were reviewed on staff files along with employment agreements, reference checking, criminal vetting, completed orientations and competency assessments (as appropriate). Copies of annual practising certificates are current for all staff that require them to practice.</p> <p>An appraisal schedule is in place and current staff appraisals were sighted. Registered and enrolled nurses complete their professional development recognition programme (PDRP) via the local District Health Board (DHB).</p> <p>An orientation/induction programme is available and all new staff are required to complete this prior to their commencement of care to residents. The RN educator advised that staff are orientated for at least two shifts at the beginning of their orientation. The entire orientation process, including completion of competencies, takes up to four months to complete and staff performance is reviewed at the end of this period. Orientation for staff covers the essential components of the service provided.</p> <p>Care staff confirmed they have completed an orientation, including competency assessments (as appropriate). Care staff also confirmed their attendance at on-going in-service education and the currency of their performance appraisals.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or</p>	<p>FA</p>	<p>There was a documented rationale in place for determining service provider levels and skill mixes in order to provide safe service delivery. Registered nurse (RN) cover is provided 24 hours a day, seven days a week in both buildings. The minimum amount of staff on duty is between 11pm and 7.00am and consists of two registered nurses and 10 caregivers. The two dementia units have at least two caregivers on duty at all times.</p> <p>Care staff interviewed reported there is adequate staff available and that they are able to get through their work. All staff are required to have current first aid certificates and there is at least one staff member with a current</p>

experienced service providers.		<p>first aid certificate on each shift. Residents and family interviewed reported staff provide them with adequate care.</p>
<p>Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>The clinical managers and registered nurses reported that prescribed medications were delivered to the facility and checked on entry. The medication areas, including controlled drug storage areas were appropriate and secure, free from heat, moisture and light, with medicines stored in original dispensed packs. The controlled drug register was maintained. Registered nurses completed weekly checks and six monthly physical stock takes were completed by the pharmacists. The medication fridge temperatures were conducted and recorded.</p> <p>Staff members authorised to administer medicines had current competencies. The morning medication round was observed. The staff interviews confirmed staff members were knowledgeable about the medicine administered and signed off. Administration records were maintained, as were specimen signatures. Staff education in medicine management was conducted.</p> <p>Each resident file reviewed had an individual medicines profile and medicine prescription form with an individually dispensed medicines and medicine signing sheets. Medicine charts sampled evidenced residents' photo identification, allergies recorded, medicine charts were legible, three monthly medicine reviews were conducted and discontinued medicines were dated and signed by the GPs. There were three residents in the rest home who self-administer medicines. There is a policy on self-administration of medication by competent residents. Self-administration of medicines was monitored and resident competencies reviewed.</p> <p>The previous requirements for improvement relating to medicines management was fully implemented. Criterion 1.3.12.1 was rated as partially attained during the last audit in June 2013 and is fully attained.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>Food, fluid, and nutritional needs of residents were provided in line with recognised nutritional guidelines. Additional requirements and modified needs were being met. The resident's individual needs were identified on admission, documented in nutrition and dietary profiles, and reviewed. Menus were planned and annually reviewed by the dietitian.</p> <p>Resident interviews reported the food service was adequate and confirmed that their preferences are being met. Fluids were provided and snacks were available between meals. Additional supplements were offered to residents who were under-weight. Short term care plans were used for residents who experience unintentional weight loss. Residents' files demonstrated regular monthly weighing.</p> <p>Residents' lifestyle care plans identified nutritional needs and interventions to achieve these goals have been documented. Residents were referred to their GP or the dietitian for investigation when unintentional weight</p>

		<p>loss was experienced. Residents with swallowing difficulties were referred to a speech language therapist when required.</p> <p>Inspection of the kitchen and food preparation areas evidenced the areas were maintained and clean. Fridge and freezer and food temperatures were monitored daily. Food temperatures were monitored at every meal.</p> <p>Staff received education on safe food handling requirements, chemical safety and infections control. Food supplies were obtained from a national provider. Emergency food and water supply was stored at the facility.</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>	FA	<p>The residents' files evidenced the GP documentation and records were current and that consultation and liaison was occurring with other services. Interventions were based on the assessed needs, desired outcomes or goals of the residents. The general practitioners' (GP) documentation and records were current.</p> <p>There were adequate continence and dressing supplies in accordance with requirements of the service agreement. In interviews, residents and family confirmed their and their relatives' current care and treatments they were receiving met their needs and their involvement in the care planning process.</p> <p>Nursing progress notes and observations charts were maintained. The family communication sheet confirmed communication with family.</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>In interview, the diversional therapist (DT) confirmed the activities programme met the needs of the service group.</p> <p>Residents, family and staff interviews confirmed the activities programme included input from external agencies and supported ordinary, unplanned and spontaneous activities that included festive occasions and celebrations. Regular exercises and outings were provided. The residents in all three areas of service were actively engaged in activities during the on-site visit. Interview with the DT confirmed that resident received weekly activities programmes and have a variety of activities to choose from.</p> <p>The DT was responsible for conducting residents' activities assessments and implementation and evaluation of the activities programme. The activities care plans were part of the person centred care plans and conducted by the RNs in consultation with the DT and the activities coordinator. The residents' activities attendance records were maintained, sighted. The residents' meeting minutes evidenced residents' involvement and consultation of the planned activities programme.</p> <p>The residents' files demonstrated the individual activities care plans were current and individualised.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Interviews with staff reported that family were notified of any changes in resident's condition. The communication with family members was recorded in residents' files.</p> <p>Residents' files provided evidence that care plans were evaluated within stated timeframes, six monthly. Evaluations were conducted by the registered nurses (RN) with input from the other RN's, the resident, family, care and activity staff. Multidisciplinary reviews were current. When resident's progress was different than expected, the RN contacted the GP, as required. Short term care plans were used when required.</p> <p>Time frames in relation to care planning evaluation were documented. There was recorded evidence of additional input from professionals, specialist or multi-disciplinary sources, if this was required. The residents' files evidenced referral letters to specialists and other health professional when this was required. Updated care plans reflect changes in the condition of residents. Criterion 1.3.8.3 was rated as partially attained during the last audit in June 2013 and is fully attained.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Criterion 1.4.1.1. was rated as partially attained during the last audit in June 2013 and is fully attained. Chemicals were observed to be safely stored. There were documented processes in place for the management of waste and hazardous substances including specifying labelling requirements. Material safety data sheets provided by the chemical representative were available and accessible for staff. Education on chemical safety has been provided for staff in October 2014. Staff interviewed reported they have received training and education to ensure safe and appropriate handling of waste and hazardous substances.</p> <p>Observations provided evidence that hazardous substances were correctly labelled, and the container was appropriate for the contents including container type, strength and type of lid/opening. Sluice facilities are provided for the disposal of waste, and protective clothing and equipment that is appropriate to the risks associated with the waste or hazardous substances being handled are provided and are being used by staff.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>There have been no building alterations undertaken at Mary Doyle Lifecare since the last audit. The service is provided in two buildings on the same site: one building has two dementia units and a hospital unit and the other building has a hospital and a rest home unit. The site also has 129 villas and 87 apartments and studios.</p> <p>An ongoing maintenance programme is in place that is overseen by a maintenance person. The maintenance person advised external contractors are used for plumbing, electrical and other specialist areas. The maintenance person confirmed there is a maintenance programme in place that ensures buildings, plant and equipment are maintained to an adequate standard. Current calibration/performance verified stickers were observed on medical equipment. Electrical items had current electrical tags. There is a current Building Warrant of Fitness in each building that expires 1 September 2015.</p>

		<p>Observations of the two facilities provided evidence of safe storage of medical equipment. The corridors are wide and residents were observed safely passing each other; safety rails are secure and are appropriately located.</p> <p>There are multiple external areas available for residents and these are safely maintained and are appropriate to the resident groups and setting. Residents are protected from risks associated with being outside including provision of adequate and appropriate seating; provision of shade; and ensuring a safe area is available for recreation or evacuation purposes.</p> <p>Care staff confirmed they have access to appropriate equipment; equipment is checked before use; and they are competent to use the equipment.</p> <p>Residents confirmed they know the processes they should follow if any repairs/maintenance are required and that requests are appropriately actioned. Residents confirmed they are able to move freely around the facility and that the accommodation meets their needs.</p> <p>A New Zealand Fire Service letter dated 16 July 2007 confirms the fire evacuation scheme is approved. The last trial evacuation was held on 28 October 2014. All staff are required to complete first aid education.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Documentation review provided evidence that the surveillance reporting processes were applicable to the size and complexity of the organization. Surveillance was aligned with the organisation's policies. Infections were recorded as quality indicators on intranet.</p> <p>Residents with infections had short term care plans completed to ensure affective management and monitoring of infections. Quality indicators were reported on monthly at staff, quality infection control and at the health and safety, staff meetings.</p> <p>Interviews confirmed this information was made available for clinical staff during hand over and meetings.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The definition of restraint and enabler was congruent with the definition in the Standard. Assessment, care planning, monitoring and evaluation of restraint and enabler use was recorded in policies and procedures. There were 26 residents who used restraint and 11 resident who used enablers at the facility on audit.</p> <p>Staff confirmed that the approval process for enabler use was activated when a resident voluntarily requested an enabler to assist them maintaining their independence and safety.</p> <p>The educator conducted education and training on restraint minimisation and safe practice. De-escalation techniques were used for management of challenging behaviour.</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.

No data to display

Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, there is a message “no data to display” then no continuous improvements were recorded as part of this audit.

No data to display

End of the report.