

# Mary Doyle Healthcare Limited - Mary Doyle Lifecare

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## Introduction

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

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

<b>Legal entity:</b>	Mary Doyle Healthcare Limited
<b>Premises audited:</b>	Mary Doyle Lifecare
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 2 June 2016    End date: 3 June 2016
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	150

# Executive summary of the audit

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## 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 Lifecare Village is part of the Hurst Lifecare 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 150 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 is managed by a general manager who is suitably qualified and experienced. There are established quality systems and processes being implemented. Feedback from residents and relatives is positive about the care and services provided. An induction and in-service training programme is provided.

The service exceeds the required standard around good practice, the spark of life activities programme, reduction of urinary tract infections, restraint minimisation and injury minimisation resulting from falls.

Improvements are required around aspects of signing documents and wound documentation.

## 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.		All standards applicable to this service fully attained with some standards exceeded.
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Information about the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) was readily available to residents and families. Residents and their families/whānau are informed of their rights as part of the resident information pack. Residents and family members interviewed confirmed that their rights were met during service delivery. Cultural needs are being met. Care plans accommodate the choices of residents and/or their family/whānau. Residents receive services in a manner that considers their dignity, privacy and independence. Staff demonstrated good knowledge and practice of respecting residents' rights in their day to day interactions. There is a Maori Health Plan and implemented policy supporting practice. There are no known barriers to Maori residents accessing the service. Services are planned to respect the individual culture, values and beliefs of the individual residents. Informed consent processes are adhered to. Complaints processes are implemented, and complaints and concerns are actively managed and well documented.

## 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 service’s philosophy and vision is to ‘help our people make the most of every day’, through the values of ownership, pride, innovation, trust, spark and appreciation. This philosophy is evidenced in the organisation’s documents and management structure, to provide services that meet the needs of the residents and the community.

The service is run by a suitably qualified general manager and assistant manager (both registered nurses) who are responsible for the day-to-day operations of the facility and the general manager is responsible for the financial management in conjunction with head office. The general manager and assistant manager are supported by an organisational quality manager and four care managers. Goals are documented for the service with evidence of annual reviews. A risk management programme is in place, which includes managing adverse events and health and safety processes.

The service is implementing the established organisational quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to a number of meetings. An annual resident/relative satisfaction survey is completed and there are regular resident/relative newsletters. Interviews with staff and review of documentation, demonstrate a culture of quality improvements.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. A comprehensive orientation programme is in place for new staff. Ongoing education and training for staff is in place.

Registered nursing cover is provided 24 hours a day, seven days a week.

## Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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The welcome/introduction package which includes pamphlets and booklets, provides information about services offered within the facility and the company. This is made available to the resident and family/whānau prior to entry or on admission.

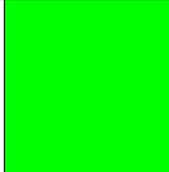
Residents on admission to the service are admitted by a registered nurse who completes an initial assessment and then develops, with the resident and family, a care plan specific to the resident. Assessments (including InterRAI) and support plans reviewed are developed and implemented within the required timeframes. When there are changes to the resident's needs a short term plan is developed and integrated into a long term plan. The residents' needs, objectives/goals have been identified in the long-term support plans and these have been reviewed at least six monthly. Resident files are integrated and include notes by the GP and allied health professionals.

The activity programme is resident-focused and provides group and individual activities planned around everyday activities.

There are medicine management policies and procedures in place. Medication is managed using a computerised medication management system. The electronic medication charts meet legislative prescribing requirements and are reviewed by the GP three monthly.

Meals are cooked on site and food service staff are aware of resident's likes/dislikes and alternative choices are offered.

## 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. All 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 adequate equipment for the safe delivery of care. All equipment is well maintained and on a planned schedule. The main site laundry operates throughout the day. The cleaning service maintains a tidy, clean environment. Staff are trained in emergency management procedures. There is water, food and equipment stored for use in 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.
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Mary Doyle Lifecare has a comprehensive restraint minimisation policy. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. The service has focused on and been successful in reducing the number of residents using restraint. There were seven residents using an enabler and eleven residents with restraints. Enablers are assessed as required for maintaining safety and independence and are used voluntarily by the residents. Staff receive training on restraint minimisation and managing residents' behaviours that can be challenging. Review of restraints used occurs monthly and there is a six monthly restraint approval group meeting.

## 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.		All standards applicable to this service fully attained with some standards exceeded.
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Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. Documented policies and procedures 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.

## 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)
<b>Standards</b>	2	46	0	2	0	0	0
<b>Criteria</b>	4	95	0	2	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0



# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The 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 resident's 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. Six relatives (two dementia care and three hospital level and one rest home) and 15 residents (12 rest home level and three hospital level) interviewed stated they were provided with information on admission which included the Code.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. The resident or their EPOA signs written consents. Thirteen resident files sampled (three rest home, five hospital and five dementia), demonstrated that advanced directives are signed for separately. There is evidence of discussion with family when the GP has completed a clinically indicated 'not for resuscitation' order. Caregivers and registered nurses interviewed confirmed verbal consent is obtained when delivering care. Family members are involved in decisions that affect their relative's lives. All thirteen resident files sampled had an admission agreement signed on or before the day of admission and consents.</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>Advocacy information is part of the service entry package and is on display on noticeboards around the facility. The right to have an advocate is discussed with residents and their family/whānau during the entry process. Mary Doyle Lifecare has advocate pamphlets available at the facility entrance and posters are displayed throughout each unit. Advocacy services staff training last occurred in November 2015. Interviews with family confirmed they were aware of their right to access advocacy.</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>Interviews with residents and relatives confirm that visiting can occur at any time and families are encouraged to be involved with the service and care. Activity staff support residents to access the community as required, including shopping, church visits, outings, entertainment. The service maintains key linkages with other community organisations.</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 at entry to the service. The facility manager maintains a record of all complaints, both verbal and written, by using a complaints register. Documentation, including follow-up letters and resolution, demonstrates that complaints are managed in accordance with guidelines set forth by the Health and Disability Commissioner.</p> <p>Discussions with residents and relatives confirmed they were provided with information on complaints and complaints forms. Complaints forms and a suggestions box are in a visible location at the entrance to the facility. The three complaints received in 2015 were reviewed, with evidence of appropriate follow-up actions taken.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<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. 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>Standard 1.1.3: Independence,</p>	<p>FA</p>	<p>During the audit, staff were observed to be respectful of residents' privacy by knocking on doors prior</p>

<p>Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>		<p>to entering resident rooms. Residents are treated with dignity and respect. 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. Values and beliefs information is gathered on admission with family involvement and is integrated into the residents' care plans. Privacy and dignity training was provided in May and June 2015. Care staff interviewed are able to discuss ways in which they would manage suspected abuse or neglect. Abuse and neglect training last occurred in May, June and September 2015, with 51 staff attending.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>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 participation and input of the family/whānau in the day-to-day care of the resident. During this audit, there were three Māori residents (one dementia care, one rest home level and one hospital level) living at the facility. There are established links with disability and other community representative groups, as directed/requested by the resident/family/whānau.</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 implements policies around recognition of individual values and beliefs. This includes cultural, religious, social and ethnic needs. Staff recognise and respond to values, beliefs and cultural differences. Values and beliefs information is gathered on admission with family/whānau involvement and is integrated into residents' care plans. Interviews with family confirm values and beliefs are considered. Residents are supported to attend church services of their choice if appropriate.</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 employment policies/procedures include confidentiality, house rules and staff expectations. Staff comply with confidentiality and the code of conduct. Job descriptions include responsibilities of the position. Signed copies of all employment documents are included in staff files. Interviews with care staff confirmed an awareness of professional boundaries. Resident interviews confirmed that staff were very caring and supportive.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an</p>	CI	<p>Evidence-based practice is evident, promoting and encouraging good practice. Registered nursing staff are available seven days a week, 24 hours a day. Residents identified as stable are reviewed by the general practitioner (GP) every three months with more frequent visits for those residents whose</p>

<p>appropriate standard.</p>		<p>condition is not deemed stable.</p> <p>The service receives support from the District Health Board which includes visits from the older person's mental health team and nurse specialist's visits. Physiotherapy service are provided two hours per week and the service employs an enrolled nurse as a restorative therapist an additional two days per week.</p> <p>There is a regular in-service education and training programme for staff. The service has links with the local community and encourages residents to remain independent.</p> <p>The GP interviewed was satisfied with the level of care that is being provided.</p> <p>The service has a number of examples of good practice including resident independence supported with meal choice and the implementation of the Spark of Life programme.</p> <p>Other examples of good practice are documented the reduction of restraint, (link to 2.2.5) the reduction of urinary tract infections (link to 3 5.7) and the reduction of falls (link to 1.2.3.6).</p> <p>Other improvements include; maintaining tertiary level in the ACC workplace safety, review of how education is delivered to enable greater attendance by staff, and the site has implemented an electronic medication chart system (Medi-Map).</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Full information is provided on admission for residents and family/whānau. Families are involved in the initial care planning process and around ongoing care. Regular contact is maintained with family, including if an incident/accident, care/medical issues or complaints arise. Management have an open-door policy. Relatives interviewed stated that they are always informed when their family members health status changes. Families receive newsletters that keep them informed on facility matters and events. Resident/family meetings encourage open discussion around the services provided. The general manager advised access to interpreter services is available if required, via the local community and district health board.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Mary Doyle Healthcare Limited (Mary Doyle) is a Hurst Lifecare residential care facility. The service provides hospital (geriatric and medical), rest home and dementia level care for up to 161 residents.</p> <p>The service is divided across five separate units; two dementia units (64 beds), one rest home only unit and two units with a combination of hospital and dual purpose beds (rest home and hospital). There are ten dual-service rest home/hospital beds and currently three certified rest home beds in serviced apartments.</p>

		<p>On the day of the audit there were 53 hospital level residents, 58 residents across the two dementia units and 39 rest home level residents; Bramlee unit (rest home only) had 32 residents; Nimon unit (dual purpose beds) had three rest home and 19 hospital residents; Reeve unit (dual purpose beds) had three rest home and 34 hospital residents. There was one rest home resident in the serviced apartments. For the two dementia units; Ashcroft had 33 residents and Goddard had 25 residents</p> <p>Residents were under the following contracts; 150 residents Age Related Care agreement and one EngAGE (DHB contract).</p> <p>A vision, mission statement and objectives are in place. Annual goals for the facility have been determined, which link to the overarching Hurst Lifecare Group strategic plan.</p> <p>The general manager (GM) is a registered nurse with a current practising certificate. The GM has been in the role for 15 years and is very experienced in a wide range of aged care roles. She is supported by an assistant manager (RN) who has worked at the service for 14 years and four care managers (registered nurses), one for the rest home unit, one for each of the hospital units and one care manager oversees both dementia units. Service support also includes an education manager, a household manager, administration and head office support such as the quality advisor.</p> <p>The general manager and assistant manager have maintained over eight hours annually of professional development activities related to managing an aged care service.</p>
<p><b>Standard 1.2.2: Service Management</b></p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>An assistant manager/registered nurse (RN) who is employed full time, supports the general manager and steps in when the manager is absent.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement</p>	<p>FA</p>	<p>An established quality and risk management programme is in place. Interviews with the managers and staff reflect their understanding of the quality and risk management systems that have been put into place. Quality and risk data, including trends in data and benchmarked results are conveyed to the CEO and board through monthly reports. Monthly quality meetings in each of the units, daily clinical meetings, and monthly management meetings all ensure that quality outcomes and clinical issues are discussed and addressed. Staff newsletters also ensure staff are fully informed.</p> <p>Policies and procedures and associated implementation systems provide a good level of assurance</p>

<p>principles.</p>		<p>that the facility is meeting accepted good practice and adhering to relevant standards. A document control system is in place. Policies are regularly reviewed and have been updated to include interRAI requirements. New policies or changes to policy are communicated to staff.</p> <p>The monthly monitoring, collation and evaluation of quality and risk data allows analysis and quality data is benchmarked with the organisation's other services. An annual internal audit schedule was sighted for the service with evidence of internal audits occurring as per the audit schedule. Corrective action plans are developed when service shortfalls are identified.</p> <p>Quality and risk data, including trends in data and benchmarked results are conveyed to staff and families through relevant newsletters.</p> <p>Falls prevention strategies are in place. A health and safety system is in place. Hazard identification forms and a hazard register are in place. The organisation holds tertiary accreditation by ACC for their workplace safety management programme.</p> <p>The service has exceeded the required standard around quality and risk management systems, demonstrated in the analysis of serious harm from falls and implementing a process to reduce harm (see detail 1.2.3.6), the resident independence initiative (link to standard 1.1.8, good practice), restraint minimisation (2.2.5) and reduction in urinary tract infections (Link to standard 3.5, infection control).</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Individual incidents/accidents are completed with immediate action noted and any follow-up action(s) required. Incident/accident data is linked to the organisation's quality and risk management programme and is used for comparative purposes. Eighteen falls related accident/incident forms were reviewed. Every event involving a resident reflected a clinical assessment and follow-up by a registered nurse. Neurological observations were documented and short-term care plans put in place as needed.</p> <p>The managers are aware of their requirement to notify relevant authorities in relation to essential notifications. Since the previous audit there were appropriate notifications documented relating to three section 31 notifications to the Ministry of Health (one pressure injury, one unexpected death and one declined entry). One outbreak of norovirus and one influenza outbreak also had documented notifications as needed.</p>
<p><b>Standard 1.2.7: Human Resource Management</b></p>	<p>FA</p>	<p>There are human resources policies in place, including recruitment, selection, orientation and staff training and development. Sixteen staff files sampled included evidence of the recruitment process, employment contracts, completed orientation, and annual performance appraisals. The orientation</p>

<p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>programme provides new staff with relevant information for safe work practice and is developed specifically to worker type. Staff interviewed stated that new staff are adequately orientated to the service. The service has a designated staff educator to support new and existing staff.</p> <p>A register of practising certificates is maintained.</p> <p>There is an annual education and training schedule being implemented. Education and training for clinical staff is linked to external education provided by the district health board.</p> <p>The service is encouraging the RN PDRP process with 15 RNs now enrolled and six completed at competent level. Caregiver education includes 44% of caregivers with ACE core competencies and 52% with the National certificate in caregiving.</p> <p>There are 36 caregivers in the dementia units with 81% of caregivers having completed the required dementia standards. Eight staff are enrolled and undertaking this and have been at the service less than 12 months. Activities staff who work in the dementia unit have completed relevant training.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>Staffing levels exceed contractual requirements. The general manager, assistant manager and care managers are registered nurses who are available during weekdays. Adequate RN cover is provided 24 hours a day, seven days a week. Sufficient numbers of caregivers support RNs. Interviews with the residents and relatives confirmed staffing overall was satisfactory.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>PA Low</p>	<p>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 being locked away in the nurses' stations. Informed consent to display photographs is obtained from residents/family/whānau on admission. Other residents or members of the public cannot view sensitive resident information. Not all amendments to care plans were individually signed and dated with a designation recorded.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for</p>	<p>FA</p>	<p>The service has comprehensive admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. The service screens all potential residents prior to entry and records all admission enquires. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the manager and clinical managers. The</p>

services has been identified.		<p>admission agreement form in use aligns with the requirements of the ARRC contract.</p> <p>Written information on the service philosophy and practices particular to dementia care, (including minimisation of restraint, behaviour management and the complaints policy) are included in the information pack and near the entrance to the units.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs, using the yellow envelope system (containing the resident's current clinical information) from residential care to the DHB acute hospital. Relatives are notified if transfers occur.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>Twenty-six medication files were sampled (six rest home, ten hospital, and ten dementia level of care). The service uses an electronic medication management system. The medication management policies comply with medication legislation and guidelines. All required medication checks had been completed. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Resident's medicines are stored securely in the medication rooms.</p> <p>Medication administration practice complies with the medication management policy for the medication round sighted. Registered nurses and caregivers administer medicines. All staff that administer medicines are competent and have received medication management training. The facility uses a robotically packed medication management system for the packaging of all tablets. Two RNs reconcile the delivery of new medication and document this. There was evidence of three monthly reviews by the GP. All residents self-administering their own medication had completed the required competency assessments. Standing orders are not used.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>There is a food services policy and procedure manual. All food is cooked onsite. A dietitian has reviewed and approved the menu. All residents have a dietary requirements/food and fluid chart completed on admission.</p> <p>The cook maintains a folder of residents' dietary requirements that include likes/dislikes. Alternatives are offered and alternatives are provided as needed.</p> <p>Specialised utensils and lip plates are available as required. Residents and relatives interviewed confirm likes/dislikes are accommodated and alternatives offered. Fridge and freezer temperatures are recorded daily for the kitchen appliances. Perishable foods in the chiller and refrigerators are</p>



		date-labelled and stored correctly. The kitchen is clean and has a good workflow. Chemicals are stored safely and safety datasheets are available. Personal protective equipment is readily available and staff were observed to be wearing hats, aprons and gloves. The service has implemented an empowering process associated with meals for residents across all areas (link CI 1.1.8.1).
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	The service records the reasons for declining service entry should this occur and communicates this decision to residents/family/whānau and the referring agency. Anyone declined entry is referred back to the referring agency for appropriate placement and advice. Information on alternate placement options is provided.
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Files sampled contained appropriate assessment tools that were completed and assessments that were reviewed at least six monthly or when there was a change to a resident's health condition. The InterRAI assessment tool is implemented and all residents have a completed InterRAI assessment in their clinical file. Care plans sampled were developed on the basis of these assessments.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	The long-term care plans reviewed described the support required to meet the resident's goals and needs and identified allied health involvement under a comprehensive range of template headings. The InterRAI assessment process informs the development of the resident's care plan. Residents and their family/whānau interviewed reported that they are involved in the care planning and review process. Short-term care plans are in use for changes in health status. Staff interviewed reported they found the plans easy to follow.
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and</p>	PA Low	Registered nurses (RNs) and caregivers follow the care plan and report progress against the care plan each shift at handover (witnessed). If external nursing or allied health advice is required, the RNs will initiate a referral (eg, to the hospice nurses or the older person's mental health nurses). If external medical advice is required, this will be actioned by the GPs. Staff have access to sufficient medical supplies (eg, dressings). Sufficient continence products are available and resident files include a continence assessment and plan as part of the plan of care. Specialist continence advice is

<p>desired outcomes.</p>		<p>available as needed and this could be described.</p> <p>Current wound assessment, monitoring and wound management plans were reviewed. Documentation for pressure injuries was fully completed including ongoing evaluation/progress. The RNs have access to specialist nursing wound care management advice through the district health board wound care specialist.</p> <p>Interviews with registered nurses and caregivers demonstrated an understanding of the individualised needs of residents. There was evidence of pressure injury prevention interventions such as two hourly turning, food and fluid charts, regular monitoring of bowels and regular (monthly or more frequently if required) weight management.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The service employs eleven activities staff, three of whom are diversional therapists. The service also employs an RN spark of life master practitioner.</p> <p>The secure dementia unit has a specific activities programme in place to encourage functional independence and therapeutic activity.</p> <p>Activities staff provide activities for rest home and hospital level care seven days a week.</p> <p>The activity programme includes resident input and has a range of activities to meet most needs at all levels of care including entertainment, craft, walks, memory games music and DVDs. Family are included in the activities. There are also van outings. The activities staff have one-on-one time with residents who are unable or who choose not to participate in the programme.</p> <p>Dementia specific activities have included (but not limited to) making pizza, fish and chip days, communal sing-alongs and gardening.</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>The registered nurses evaluate all initial care plans within three weeks of admission. There was at least a three monthly review by the GP. All changes in health status were documented and followed up. Since 1 July 2015, reassessments have been completed using InterRAI LTCF for all residents who have had a significant change in health status. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files sampled. Where progress is different from expected, the service responds by initiating changes to the care plan.</p>

<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The RNs initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family, as evidenced in medical notes. The staff provided examples of where a resident's condition had changed and the resident was reassessed.</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>There are policies and procedures in place for the storage and use of chemicals. There is a locked chemical store room that is located between the main kitchen and laundry. Chemicals distributed to the areas are recorded and signed out. Safety data sheets are available in each unit (nursing station), in the laundry areas, in the chemical storeroom and at the main reception for staff. There is a Chemicals spills kit readily accessible. There have been no incidents regarding chemical spillage or accidents. There are policies and procedures in place for the management of waste. A contract is in place for waste management collection. Clinical waste including incontinent products are disposed of into the skip bin ready for collection.</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>Mary Doyle Lifecare includes Bramlee rest home unit and Nimon hospital unit 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 warrant of fitness certificates. There is a fire service evacuation approval letter is dated July 2007, with the most recent fire evacuation drill held on 17 May 2016. There is a reception area at each building. The facilities are well maintained and set in attractive grounds. The interior is modern, purpose built and has a home like atmosphere. Staff amenities include staff toilets, staff team rooms and a training room. The Riverstone café located between the two buildings is available for residents and families during the day and can be booked for special functions.</p> <p>There are monthly, six monthly and annual maintenance schedules that include water temperature monitoring and equipment planned maintenance records (sighted). Electrical equipment is checked and medical equipment calibration and servicing occurs annually. There is adequate space in the facilities for storage of mobility equipment. Residents were observed to safely access the outdoor gardens and courtyards. Wheelchair access, seating and shade is provided. There is a safe and secure outside area that is easy to access for residents of the dementia units with outdoor seating and umbrellas for shade. There is an external security gate for an emergency evacuation.</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>All but two rooms in the Nimon (hospital) bedrooms have ensuites. The communal toilets and bathroom are in close proximity to those two bedrooms and there are toilets near the communal areas. The Bramlee (resthome) and Reeve (hospital) unit bedrooms have ensuites. There are large shower trolley bathrooms and a bath available which staff advise are rarely used. All bedrooms in the Goddard and Ashcroft dementia care units have ensuites. Handrails are appropriately placed in ensuite bathrooms and communal showers and toilets. Privacy is assured with the use of ensuites, privacy curtains and "care in progress" notices on bedrooms doors as observed over the two days of audit.</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 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.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>The Bramlee rest home unit has seating and a shared library near the reception area. Bramlee rest home and Nimon hospital units have large lounge and dining areas. Seating is placed appropriately to allow for group and individual activities to occur. The dining rooms in the Goddard and Ashcroft dementia units and Reeve hospital unit are spacious enough provide an additional area for activities. The dining room walls in all areas are brightly decorated with residents' art and other items. The lounges at each end of the units open out into the courtyard. Reeve Hospital unit provides seating areas and a main lounge with a piano and smaller lounge for residents and visitors. All the corridors in both buildings are wide with appropriately placed handrails. Residents have easy access to communal areas for relaxation, dining and activities. There are quiet areas where residents/families may have private meetings. Residents interviewed state that they are happy with the dining and lounge facilities.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe</p>	FA	<p>The main laundry which is located in the Reeve building has separate rooms for the washing and drying of laundry. The laundry operates from 7.00am to 12.00pm. Laundry is sorted on arrival with the exception of soiled and infectious linen in red bags. There are hand washing facilities within the laundry. Appropriate personal protective wear (aprons, goggles, gloves etc.) is readily available for</p>

<p>and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>		<p>the sluicing and sorting of linen. Chemicals bottle are kept in a locked cupboard. There is a smaller laundry at the Bramlee unit that launders all the personal clothing for the Bramlee and Nimon units. There are product wall charts and safety data sheets available in both laundry areas. Quality controls checks are carried out on laundry and cleaning products, equipment and processes. There are cleaners employed for each unit. They have fully equipped cleaner's trolleys which are locked away at the end of the shift.</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. Appropriate training, information and equipment for responding to emergencies is provided. Fire training evacuations are held six monthly. The last fire evacuation was held on 17 May 2016. There is an approved fire evacuation plan dated 16 July 2007. There is a first aid trained staff member on every shift. A store of emergency tank water is available and there is access to stored water.</p> <p>There are six BBQs and gas bottles for alternative heating and cooking. Emergency food supplies sufficient for three days, are kept in the kitchen. Extra blankets are also available. There is a list of resident names and contact details of staff so that they can easily be contacted in an emergency. There is a store cupboard of supplies necessary to manage a pandemic. The call bell system is available in all areas and indicator panels in each unit. During the tour of the facility and during interviews, residents were observed to have easy access to the call bells. The facility is secured at night. The front door is locked by staff at 9.00pm and opens at 6.45am. Visitors use the call button for staff assistance.</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>	<p>FA</p>	<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. Residents interviewed confirm that the environment is warm and comfortable.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment,</p>	<p>FA</p>	<p>Mary Doyle has an established infection control (IC) programme that is implemented. The infection control programme is appropriate for the size, complexity and degree of risk associated with the service and has been linked into the incident reporting system and the quality management system.</p>

<p>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>		<p>One registered nurse is the designated infection control nurse with support from the clinical team, care managers and the quality manager. The IC team meets three monthly to review infection control matters. Regular audits have been conducted and education has been provided for staff and where required, residents (link 3.5). The infection control programme has been reviewed annually.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>There are adequate resources to implement the infection control programme at Mary Doyle. The infection control (IC) coordinator has maintained her practice by attending infection control updates. The infection control team is representative of the facility. External resources and support are available when required. The IC coordinator is part of the DHB IC support group and journal club.</p> <p>Infection prevention and control is part of staff orientation and induction, and the planned education programme.</p> <p>Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<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. The policies are reviewed and updated at least annually.</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>The facility is committed to the on-going education of staff and residents (link 3.5). Education is facilitated by the staff educator with support from the infection control coordinator. All infection control training has been documented and a record of attendance has been maintained. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak had been resolved. Posters regarding hand hygiene, and cough etiquette were sighted. Information is provided to residents that are appropriate to their needs and this was documented in clinical records.</p>

<p><b>Standard 3.5: Surveillance</b></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>CI</p>	<p>The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. Infections are included on a monthly register and a monthly report is completed by the infection control co-ordinator. Infection control data is collated monthly and included in benchmarking. The infection control programme is linked with the quality management programme. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP's who advise and provide feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility. Two outbreaks; norovirus in the dementia unit (March 2015) and influenza in the hospital unit (July 2015) were well managed and contained within two weeks; all relevant authorities notified.</p>
<p><b>Standard 2.1.1: Restraint minimisation</b></p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>There is a documented definition of restraint and enablers which is congruent with the definition in NZS 8134.0. The facility has determined the only items used as restraints are lap belts and bed rails. Restraints are used only where it is clinically indicated and justified and where other de-escalation strategies have been ineffective. The policies and procedures are comprehensive and include definitions, processes and use of restraints and enablers. The service has focused on and been successful in reducing the number of residents using bed rails or lap belts.</p> <p>During the audit, there were seven residents using an enabler and eleven residents with restraints. Enablers are assessed as required for maintaining safety and independence and are used voluntarily by the residents. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. Staff training is in place around restraint minimisation and enablers, falls prevention and management of challenging behaviours.</p>
<p><b>Standard 2.2.1: Restraint approval and processes</b></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</p>	<p>FA</p>	<p>The general manager (registered nurse) is the restraint coordinator for the facility. A job description is in place which has defined responsibilities. The restraint standards are being implemented and implementation is reviewed through internal audits, staff meetings and restraint approval group meetings. The restraint approval group includes a consumer representative, educator, restorative therapist, care managers and restraint coordinator who meet six monthly.</p>

providers and 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>Assessments are undertaken by suitably qualified and skilled staff on consultation with the resident and their family/whanau. Restraint assessments are based on information in the care plan, resident discussions and on observations of the staff. There is a restraint and enabler assessment tool available and are completed for the residents assessed as potentially requiring the use of an enabler or restraint. Ongoing consultation with the resident and family/whanau is also identified.</p> <p>Assessments are completed as required and to the level of detail required for the individual residents. Five restraint files were reviewed. All included completed assessments that considered those listed in 2.2.2.1 (a) - (h) and these were reviewed monthly.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The service has an approval process and approved restraints (bed rail and lap belt) are documented in the policy. The approval process includes ensuring the environment is appropriate and safe. Assessments/care plan identifies specific interventions or strategies to try (as appropriate) before use of restraint.</p> <p>Restraint authorisation is in consultation with the residents (as appropriate) or family/EPOA/whanau, GP and the restraint coordinator. This identifies alternative interventions attempted and the outcome, restraint type, frequency of monitoring, observations required and review timeframe. Five resident's files reviewed with restraint identified observations and monitoring. A restraint register is in place. This is current for all residents requiring restraint. There is a separate register for those residents requesting the use of an enabler.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations have occurred three monthly as part of the on-going reassessment for the residents on the restraint register and as part of care plan review. Families are included as part of this review. A review of five resident files identified that evaluations are up-to-date. Restraint is reviewed monthly by the care managers and six monthly through the restraint approval group review meetings. Evaluation timeframes are determined by risk levels.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the</p>	FA	<p>Restraints are discussed and reviewed at the six-monthly restraint meetings, attended by the consumer representative, educator, restorative therapist, care managers, restraint coordinator. The organisation and facility are proactive in minimising restraint. Staff receive training on restraint</p>



monitoring and quality review of their use of restraint.		minimisation and managing residents' behaviours that can be challenging.
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## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.9.9</p> <p>All records are legible and the name and designation of the service provider is identifiable.</p>	PA Low	<p>The registered nurse is responsible for documenting the care plan and reviewing the assessment information. Alterations and additions to the care plans are made by the registered nurse if there is a change to the health status. Not all additions or amendments to care plans were individually dated or individually signed with a designation recorded. Not all care plans documented had been reviewed and signed by an RN.</p>	<p>i) Six of thirteen long-term care plans (two rest home, three hospital and one dementia), did not have amendments or alterations individually dated and signed with a designation recorded.</p> <p>ii) Five of thirteen short-term care plans reviewed (three hospital and two rest home), did not have amendments or alterations individually dated and signed with a designation recorded.</p> <p>iii) One of four rest home resident's self-medication assessments was not dated or signed by the registered</p>	<p>i-ii) Ensure that all amendments and alterations to care plans are individually signed and dated with a designation recorded.</p> <p>iii) Ensure that all residents self-medicating have their self-medicating assessments reviewed and signed off by an RN.</p> <p>iv) Ensure that all care plans are reviewed and signed</p>

			nurse. iv) One dementia care resident had their behavioural care plan documented by an enrolled nurse, which had not been reviewed and signed off by an RN.	off by an RN.  60 days
Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Low	The registered nurses develop the care plans based on the assessed care needs of the residents. Current wound assessment, monitoring and wound management plans were reviewed. Documentation for pressure injuries was fully completed including ongoing evaluation/progress. The RNs have access to specialist nursing wound care management advice through the district nursing service. Monitoring charts were well utilised for ongoing monitoring of residents when identified in the care plan.	There was one chronic wound in the rest home with documentation gaps identified on the initial assessment form and with the assessments completed at each dressing change. Noting the wound was being managed as per wound management plan.	Ensure that all wound documentation is fully completed to reflect assessment/progress of wounds.  90 days

## 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 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>Mary Doyle continually strives to improve services provided to residents and families. This is demonstrated through the introduction of the Spark of Life programme and proactive empowerment of residents.</p>	<p>1) In 2014, staff in the hospital, rest home and dementia units discussed how they could make the meal experience better and at the same time, encourage residents to gain and retain their independence as much as possible. In the dementia unit, a ‘breakfast club’ was established where residents serve themselves (with assistance if necessary) from a buffet style breakfast. The success of this along with resident feedback resulted in the commencement of a “Sammies and Civvies’ lunch in the rest home once a fortnight where residents can select their own sandwich fillings and make their own lunches.</p> <p>In the separate rest home and hospital unit, staff came up with another innovative way to empower residents in choice with food. The five-week rotating menu has poached eggs as a menu choice. It was realised that perhaps not all residents like their eggs poached and may prefer these cooked another way. Staff commenced an Egg-sellent day – with cooking at the unit, rather than transporting the cooked eggs from the kitchen. Staff who have completed safe</p>

			<p>food handling set up an area with fry pans etc. and the day before are requested to make a choice on how they would like their eggs cooked.</p> <p>Residents in the dementia units have been noticed assisting each other to get breakfast and some residents have gained weight. Residents in the rest home who engage in the 'Sammies and civvies' lunches, report an increased sense of self-worth and value.</p> <p>The implementation of these initiatives has resulted in residents feeling more enabled and involved in their daily living. There is improved resident-staff interaction, and the experience overall has given the residents the ability to develop friendships and make their own choices.</p> <p>The sense of a community kinship has developed throughout units. Camaraderie between staff and residents has provided a more positive approach to routine activities, which has created a more jovial and open environment.</p> <p>Residents and families report that residents have benefited from the independence and friendships gained and this is reflected in resident and family satisfaction survey outcomes</p> <p>2) The general managers and directors wanted to improve on the care model and change the culture of care to a person-centred approach. In November 2014, representatives from Hurst Lifecare facilities attended a two-week workshop in Perth on the Spark of Life philosophy. Following this, a process of training all staff in the philosophy was commenced; currently 90% of staff have attended an introductory training session. Family sessions were also provided. The service has noted an improved engagement of staff with resident. Caregivers on the day of audit were committed to the philosophy during interview. The 2015 surveys documented 85% very good or good overall care satisfaction, following the initial implementation. Resident engagement has improved. There has been a reduction in the use of sedative medication; from 21 residents prescribed regular benzodiazepines (February 2015) to 17 residents (April 2016). Similarly, there has been a more significant reduction in regular anti-depressants, with 50 residents (February 2015) to 38 residents (April 2016).</p>
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<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	<p>CI</p>	<p>There is an established comprehensive quality and risk management process in place. Monitoring in each area is completed monthly, quarterly, six monthly or annually as designated by the internal auditing programme schedule.</p> <p>Audit summaries and action plans are completed as required, depending on the result of the audit. Key issues are reported to the appropriate committee (eg, quality, staff, and an action plan) is identified. These were comprehensively addressed in meeting minutes (sited).</p> <p>Benchmarking reports are generated throughout the year to review performance over a</p>	<p>Mary Doyle is active in analysing data collected monthly, around accidents and incidents, infection control, restraint etc.</p> <p>In mid-2013, a specific falls management plan was put in place, with the cooperation of the DHB, and GPs, with the aim of reducing the number of serious injuries because of falls. The action plan included two monthly pharmacy and clinical meetings. Vitamin D use was promoted with GPs and monitored, and poly pharmacy reviewed and reduced where possible. Feedback and involvement from the health and safety team was also included. A resident exercise programme was commenced with residents. Training was provided to staff on the use of the DHB falls risk assessment tool (MRFRAT) and this was used to identify residents with a high risk of falls.</p> <p>In 2014, 75% of residents took Vitamin D, and during that period, there were 15 fractures. In 2015, there was a 10% increase in the uptake of Vitamin D (to 84.5%). There were seven fractures. Two of the residents who fractured were not taking Vitamin D. Of those fractures, only 57% were 'major' bones. This is a reduction of falls with fracture from 18 during 2013. The service continues to implement this falls preventions programme.</p> <p>The evidence clearly shows that serious harm for residents reduced considerably.</p>

		<p>12-month period.</p> <p>There is also a number of ongoing quality improvements identified through meeting minutes and as a result of analysis of quality data collected. Mary Doyle is proactive in developing and implementing quality initiatives.</p>	
<p>Criterion 3.5.7</p> <p>Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>	CI	<p>There is a robust infection control process in place. Monitoring in each area is completed monthly and is reported to clinical and quality meetings, to the CEO and quality manager. Three monthly IC meetings are also undertaken where trends are reviewed. These were addressed in meeting minutes sited.</p>	<p>Infection-control data review documented a high urinary tract infection rate amongst rest home residents early 2015.</p> <p>The service implemented a process of staff education to ensure staff awareness of IC practices. As the residents were rest home level (and more independent), the service provided a series of resident based interventions. These included education to residents at resident meetings, around the physiology of the urinary system, ways to reduce the risk of urinary tract infections with thorough hygiene methods and the importance of hand hygiene. An (optional) quiz was also provided to residents to reinforce learning.</p> <p>This resulted in a marked reduction of UTIs from eleven in March 2015 to two in July 2015. With continued proactive education the service has continued to maintain this low level of UTIs with less than four a month during 2016 and only two UTIs for April 2016.</p>
<p>Criterion 2.2.5.1</p> <p>Services conduct comprehensive reviews</p>	CI	<p>Six-monthly restraint meetings discuss and review restraints.</p>	<p>Mary Doyle Lifecare has identified quality goals for each year. One quality goal was around reducing restraint use. In April 2015, it was identified that there were 33 restraints (14 lap belts and 19 bedrails)</p>

<p>regularly, of all restraint practice in order to determine:</p> <p>(a) The extent of restraint use and any trends;</p> <p>(b) The organisation's progress in reducing restraint;</p> <p>(c) Adverse outcomes;</p> <p>(d) Service provider compliance with policies and procedures;</p> <p>(e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;</p> <p>(f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;</p> <p>(g) Whether changes to policy, procedures, or guidelines are required; and</p> <p>(h) Whether there are additional education or training needs or changes required to existing education.</p>		<p>Individual use of restraint occurs monthly, in a proactive attempt to reduce the use of restraint and to access alternatives prior to restraint use. Restraint practices are used only where it is clinically indicated and justified and where other de-escalation strategies have been ineffective. Staff receive training on restraint minimisation as part of the services annual training schedule.</p>	<p>and 11 enablers. The restraint approval group met in April 2015 to review the use of restraints. Discussions included reviewing the risks and benefits of restraint and seeking alternatives in place of using bedrails or lap belts. Resources were needed to provide alternative options, such as snag alarms, where an alarm is clipped to residents' clothes and will activate when the resident moves to rise. This negates the need for a lap belt. Alternative resources were also trialled for bedrails. These included perimeter mattresses (with upward curved sides to define the mattress edge), ultra-low beds (set at the lowest height 20cm with brakes activated) and floor sensor mats to alert when a resident may attempt unsupervised exit. This proactive approach enabled staff to use alternatives if the resident is at risk of unsupervised movement to support restraint minimisation. Analysis shows a definite decrease in April 2016, with eleven restraints (4 lap belts and 7 bedrails) and seven enablers in use. The care managers continue to work with clinical staff, residents and family to minimise restraint use.</p>
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End of the report.