

# Mary Doyle Healthcare Limited - Mary Doyle Lifecare

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## 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 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: 21 May 2018    End date: 22 May 2018
<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>	154

# 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 is part of the Arvida Group. The service is certified to provide rest home, hospital and dementia level of care for up to 161 residents across the care centre and serviced apartments. On the day of the audit there were 154 residents. There is an experienced village manager who reports to the Arvida group board of directors. She is supported by an assistant manager/clinical manager and care managers of each unit.

The relative and residents interviewed all spoke positively about the care and support provided at Mary Doyle Lifecare.

This unannounced surveillance audit was conducted against a subset of the health and disability sector standards and the district health board contract. The audit process included the review of policies and procedures, the review of resident and staff files, observations and interviews with residents, family members, general practitioner, staff and management.

Two of two previous findings around resident records and wound documentation have been addressed.

The service has maintained a continual improvement rating around surveillance of infections.

## 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.
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The service has a culture of open disclosure. Families are regularly updated of residents' condition including any acute changes or incidents. Residents and family member interviewed verified ongoing involvement with the community. Complaints processes are implemented, and complaints and concerns are actively managed and well documented.

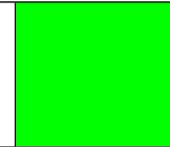
## Organisational management

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.		Standards applicable to this service fully attained.
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Mary Doyle Lifecare is implementing a quality and risk management system that supports the provision of clinical care. The service is run by a suitably qualified village manager and clinical manager (both registered nurses) who are responsible for the day-to-day operations of the facility. The village manager and clinical manager are supported by three care managers. Quality activities are conducted which generates opportunities for improvement. Corrective actions are developed and implemented. There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

## 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.

The registered nurses are responsible for each stage of service provision. A registered nurse assesses, plans and reviews residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans reviewed demonstrated service integration and were evaluated at least six monthly. InterRAI assessments are utilised and linked to care plans. Resident files included medical notes by the general practitioner and visiting allied health professionals.

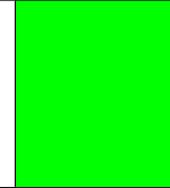
Medication policies reflect legislative requirements and guidelines. Registered nurses responsible for administration of medicines complete education and medication competencies. The medicine charts were reviewed at least three monthly by the general practitioner.

Each unit coordinates and implements an activity programme to meet the cognitive, physical and recreational needs of the residents. The programmes include community visitors and outings, entertainment and activities that meet the individual abilities and preferences for each resident group.

All meals are cooked on-site. Residents' food preferences and dietary requirements are identified at admission. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines. There are nutritional snacks available 24 hours.

## 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.

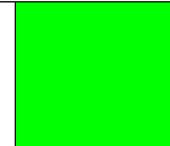


Standards applicable to this service fully attained.

The buildings hold a current warrant of fitness.

## 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.

The service has policies and procedures to ensure that restraint is a last resort. Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. At the time of the audit there were nine residents with restraints and four residents using enablers. The files for the residents with enablers showed that enabler use is voluntary. Staff receive training in restraint minimisation.

## 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.

The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	1	16	0	0	0	0	0
<b>Criteria</b>	1	41	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)
<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 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a complaints policy and procedure in place and residents and their family/whānau are provided with information on the complaints process on admission via the information pack. Complaints forms, and a suggestions box are in a visible location at each entrance of the services. Staff are aware of the complaints process and to whom they should direct complaints. The village manager maintains a record of all complaints, both verbal and written, by using a complaints register. There have been five complaints made in 2017 and five received in 2018 year-to-date. The ten complaints reviewed have been managed appropriately with acknowledgement, investigations and responses recorded. Residents and family member advised that they are aware of the complaints procedure and how to access forms.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	FA	<p>Full information is provided on admission for residents and family/whānau. Eight residents (five hospital and three rest home) interviewed, confirmed they were given an explanation about the services and procedures and that their cultural needs are being met. Management have an open-door policy. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Twelve incident/accidents had documented evidence of family notification or noted if family did not wish to be informed. Three family members (one rest home and two dementia) interviewed confirmed that they are notified of any changes in their family member's health status and are involved in the resident's care planning. Interpreter services are available as required.</p>

conducive to effective communication.		
<p><b>Standard 1.2.1: Governance</b></p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Mary Doyle Healthcare Limited (Mary Doyle Lifecare) is owned and operated by the Arvida Group, which was purchased in October 2017. The service provides hospital (geriatric and medical), rest home and dementia level care for up to 161 residents. The service is divided across five separate units; two hospital units (Nimon 23 beds and Reeve 37 beds) with a combination of 50 hospital and 10 dual-service rest home/hospital beds, one 37-bed rest home only unit (Bramlee) and two dementia units (Ashcroft 34 beds and Goddard 30 beds) and currently three certified rest home beds in the serviced apartments.</p> <p>On the day of the audit there were 154 residents in total, 49 hospital level residents including one resident on an ACC funded contract, 61 residents across the two dementia units including one resident on a long-term support chronic health condition (LTS-CHC) contract, 44 rest home level residents including two rest home residents in the serviced apartments. All other residents were on the aged related residential care (ARRC) contract.</p> <p>The village manager is a registered nurse (RN) with a current practising certificate. The village manager has been in the role for 17 years and is very experienced in a wide range of aged care roles. She is supported by a clinical manager (RN) who has worked in the position for one year and at the service for three years. The village manager and clinical manager (who also acts as the assistant manager) are supported by three care managers (one in the rest home unit, one across the hospital units and one that oversees both dementia units), the general manager operations, general manager wellness and care and a national quality manager.</p> <p>The village manager reports to the general manager operations on a variety of operational issues and provides a monthly report. Arvida has an overall business/strategic plan. The organisation has a philosophy of care, which includes a mission statement. Mary Doyle Lifecare has a business plan for 1 April 2017 to 31 March 2019. Achievements against these plans are recorded on an action plan and are reviewed by the senior operations team at least annually. Regular meetings are held between the village manager and head office as well as weekly meetings between the village manager and assistant/clinical manager.</p> <p>The village manager and clinical manager have maintained over eight hours annually of professional development activities related to managing an aged care service.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established,</p>	FA	<p>There is a business plan that includes quality goals and risk management plans for Mary Doyle Lifecare. Interviews with staff confirmed that there is discussion about quality data at various staff meetings. The village manager is responsible for providing oversight of the quality programme on-site, which is also monitored at organisational level. The quality and risk management programme is designed to monitor contractual and standards compliance. Staff interviewed could describe the quality programme corrective action process. The site-specific service's policies are currently being transitioned over to the Arvida Group policies, which are reviewed at least every two years across the group. Head office sends new/updated policies and are available to staff on the intranet. Data is collected in</p>

<p>documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>relation to a variety of quality activities and an internal audit schedule has been completed. Areas of non-compliance identified through quality activities are actioned for improvement. The service has a health and safety management system that is regularly reviewed. Restraint and enabler use is reviewed at the monthly quality committee meeting.</p> <p>Health and safety goals are established and regularly reviewed at the village manager's monthly teleconference meeting. Risk management, hazard control and emergency policies and procedures are being implemented and are monitored by the health and safety committee at the monthly health and safety meeting. Hazard identification forms and an up-to-date hazard register (last reviewed in January 2018) are in place. Resident/family meetings occur quarterly, and the residents and family members interviewed confirmed this. Residents/relatives are surveyed, to gather feedback on the service provided and the outcomes are communicated to residents, staff and families. The overall service result for the resident/relative satisfaction survey completed in March 2018 was at 94%. Corrective actions have been established in areas where improvements were identified, (i.e., around activities). Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>There is an accidents and incidents reporting policy. The clinical manager investigates accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at staff meetings including actions to minimise recurrence. A RN conducts clinical follow-up of residents. Twelve incident forms (five hospital, three rest home and four dementia) reviewed for March and April 2018, demonstrated that appropriate clinical follow-up and investigation occurred following incidents. Neurological observation forms were documented and completed for any unwitnessed falls.</p> <p>Discussions with the village manager and clinical manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Since the last audit there were appropriate notifications documented relating to five section 31 notifications to the Ministry of Health (three stage three pressure injuries, one in October 2017 and two in May 2018, one power outage in August 2017 and one dementia resident absconding in June 2016). One outbreak of norovirus was also notified to public health in November 2017.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource</p>	<p>FA</p>	<p>There are human resource management policies in place. This includes that the recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. Ten staff files were reviewed (one assistant/clinical manager, two care managers, one RN, one RN/educator, three caregivers, one diversional therapist and one chef manager). There is evidence that reference checks were completed before employment was offered. Annual staff appraisals were evident in all staff files</p>

<p>management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>reviewed. A copy of practising certificates is kept.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The in-service education programme for 2017 has been completed and the plan for 2018 is being implemented. Discussions with the caregivers and the RNs confirmed that ongoing training is encouraged and supported by the service. Eight hours of staff development or in-service education has been provided annually. There are 22 RNs, and 14 have completed interRAI training. There are 31 caregivers in the dementia units with 28 caregivers having completed the required dementia standards. Three staff are in progress of completing, two of those are level seven student nurses.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>Human resources policies include documented rationale for determining staffing levels and skill mixes for safe service delivery. Sufficient staff are rostered on to manage the care requirements of the residents. The service has a total of 248 staff in various roles. Staffing rosters were sighted and there is staff on duty to match needs of different shifts. The village manager and clinical manager work 40 hours per week from Monday to Friday and are available on call after hours. In addition to the village manager and clinical manager, there is a care manager in the rest home unit, hospital unit and dementia unit (all RNs). The care managers are aware that extra staff can be called on for increased resident requirements. Interviews with staff, residents and family members confirm there are sufficient staff to meet the needs of residents. The caregivers interviewed confirmed that they have sufficient staffing levels.</p> <p>The service is divided across five separate units. In the Nimon unit there are 22 of 23 residents in total (16 hospital residents and six rest home residents). There is one RN on duty in the morning and afternoon shifts, and one RN on the night shift. They are supported by five caregivers (three long and two short shifts) on the morning shift, five caregivers (three long and two short shifts) on the afternoon shift and two caregivers on the night shift. Reeve unit there are 37 of 37 residents in total (33 hospital residents and four rest home residents). There is one RN on duty in the morning and afternoon shifts, and one RN on the night shift. They are supported by seven caregivers (four long and three short shifts) on the morning shift, six caregivers (three long and three short shifts) on the afternoon shift and two caregivers on the night shift.</p> <p>In the Bramlee rest home unit there are 32 of 36 rest home residents in total. There is one RN on duty in the morning and afternoon shifts. They are supported by five caregivers (two long and three short shifts) on the morning shift, three caregivers (one long and two short shifts) on the afternoon shift and one caregiver on the night shift. The caregivers from Reeve unit cover the two rest home residents in the serviced apartments on the morning and afternoon shifts. In the dementia units, Goddard secure dementia unit there are 28 of 31 residents in total. There is one RN and one enrolled nurse (EN) on duty in the morning shift. They are supported by three caregivers on the morning shift, three caregivers on the afternoon shift and one caregiver on the night shift. In the Ashcroft secure dementia unit there are 33 of 34 residents in total. There is one RN and one EN on duty in the morning shift. They are supported by three caregivers on the morning shift, three caregivers on the afternoon shift and one</p>

		caregiver on the night shift. The RNs from the hospital units provide oversight on the afternoon and night shifts as needed.
Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	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. All amendments to care plans sighted on the paper-based documents had been dated and signed by the RN. All care plans developed had been dated and signed by the RN including care plans developed by the enrolled nurses. The service is in the process of transitioning to an electronic resident record data base where all notes including progress notes are dated, timed and the staff member is identifiable. The previous finding around resident records has been addressed.
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.	FA	There are policies and procedures in place for safe medicine management that meet legislative requirements and guidelines. Registered nurses, enrolled nurses and senior caregivers who administer medications have been assessed for competency on an annual basis. Annual education around safe medication administration has been provided. Registered nurses complete syringe driver training. Medications are stored safely in each unit. Monthly delivery of medication robotic rolls is checked against the medication charts on the electronic medication system and entered as pack checked. Medication fridges in each unit is checked weekly. All eye drops, and ointments were dated on opening. There were no residents self-medicating.  Eighteen medication charts (four rest home, six hospital and eight dementia) reviewed, had photo identification, allergy status and had been reviewed by the GP at least three monthly. Prescribing met legislative requirements and all 'as required' medication had an indication for use.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs	FA	All meals are prepared and cooked on-site by qualified chefs and cooks. They are supported by a kitchen manager and kitchenhands. Food services staff have attended food safety training. The food control plan was verified 3 May 2018. The Arvida dietitian reviews the seasonal menu. A four-weekly seasonal menu has been reviewed by the company dietitian. Dietary preferences and special diets are met including gluten free, dairy free, pureed meals and diabetic desserts. Resident dislikes are known and accommodated. The cook receives a resident dietary profile for new and respite care residents and is notified of any dietary changes. Holding temperatures of the bain mairé meals are taken. Meals are served from a bain mairé to residents in the main dining room adjacent to the kitchen.

<p>are met where this service is a component of service delivery.</p>		<p>Meals are plated and transported in hot boxes to the hospital dining room.</p> <p>Fridge and freezer temperatures are taken and recorded daily. End cooked food temperatures are recorded daily. Perishable foods sighted in the fridges were dated. All dry goods were labelled with expiry dates. The dishwasher is checked monthly by the chemical supplier. A cleaning schedule is maintained.</p> <p>Resident meetings and surveys, along with direct input from residents, provide resident feedback on the meals and food services generally. Residents and family member interviewed were satisfied with the meals and confirmed alternative food choices were offered for dislikes.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>When a resident's condition alters, the registered nurse initiates a review and if required, GP, nurse specialist consultation. There is documented evidence in the progress notes in the electronic system that indicates family were notified of any changes to their relative's health, including (but not limited to) accident/incidents, behaviours, infections, health professional visits, referrals and changes in medications. Residents and relatives interviewed state their expectations are being met.</p> <p>Adequate dressing supplies were sighted in treatment rooms in each unit. Wound management policies and procedures are in place. Wound assessment and treatment forms, ongoing evaluation form and evaluation notes were in place for residents with wounds (skin tears, chronic ulcers and pressure injuries). There was a dementia care resident admitted with a stage two sacral and two stage three ankle (left and right) pressure injuries. The service has had the wound nurse specialist and vascular service involved in the management of the pressure injuries and the chronic leg ulcers. The previous finding around wound documentation has been addressed.</p> <p>Contenance products are available and resident files include a urinary continence assessment, bowel management, and continence products identified</p> <p>Short-term care plans had been completed on the electronic system for short-term needs that guided staff in the delivery of care. Monitoring occurs for weight, blood pressure, blood sugar levels, pain, neurological observations, food and fluid charts. The RN monitors and reviews the monitoring forms daily on the electronic system. Care staff report any changes to the RN. The RNs review the electronic daily work logs, which includes such cares as position changes, food and fluid intake and toileting.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a</p>	<p>FA</p>	<p>The service employs a qualified diversional therapist (DT) for each unit to coordinate and implement a seven-day programme. They are supported by a relieving DT and activity assistants. Volunteers are involved in the activity programme with one-on-one time, piano playing, pampering and chats. A music therapist visits fortnightly. Each unit has its own programme that meets the physical, intellectual, cognitive and emotional needs of the group of residents. An Arvida Wellness Leader has been appointed at Mary Doyle to facilitate "clubs" that are resident driven to meet resident needs and align with Arvida's five pillars of health. "Clubs" are held weekly for eight weeks at a</p>

<p>consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>time and include Breakfast Club and Friendship Club. Other activities include (but are not limited to); arts, crafts, news and views, exercises (let's move it), baking, music, poems, chat room, reminiscence, walks, board games, indoor games, pampering sessions, gardening, music appreciation and movies. Community visitors include mothers and babies, pet therapy, churches and entertainers. All residents have the opportunity to go on regular van outings to community functions and go on scenic drives.</p> <p>A resident profile is completed on admission. Individual social activity plans reviewed had been evaluated six monthly. The service receives feedback and suggestions for the programme through resident meetings and surveys.</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>All initial/interim care plans for long-term residents were evaluated by the RN within three weeks of admission. Long-term care plans have been evaluated by the multidisciplinary team at least six monthly or earlier for any health changes. Written evaluations (currently all paper-based) identified if the resident/relative desired goals had been met or unmet. Family are invited to attend the MDT review and informed of any changes if unable to attend. The GP reviews the residents at least three monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the electronic progress notes.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>There are two separate buildings. Each building has a current warrant of fitness. The main care centre building warrant of fitness expires 24 October 2018. The second building warrant of fitness expires 1 June 2018. Compliance checks are underway in preparation for the new building warrant of fitness. Reactive and preventative maintenance occurs.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that</p>	<p>CI</p>	<p>Infection surveillance is an integral part of the infection control programme and is described in the Arvida group infection control manual. Monthly infection data is collected for all infections based on standard definition of signs and symptoms of infections. Surveillance of all infections is entered into the monthly on-line infection control register. The care manager/RN collates data which is analysed for trends and opportunities for improvements. Analysis of infections and corrective actions are discussed at the combined infection control/health and safety committee meetings. A monthly report is submitted to the clinical manager and distributed to each unit. The service has continued to maintain low rates of urinary tract infections in the rest home. Benchmarking occurs within the Arvida group. There has been one norovirus May 2017 in the rest home unit and outbreaks in December 2017 in</p>

<p>have been specified in the infection control programme.</p>		<p>three other units. The outbreaks were contained and well managed. Case logs, correspondence and DHB/public health notifications were sighted.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The service has policies and procedures to ensure that restraint is a last resort. There is a documented definition of restraint and enablers which is congruent with the definition in NZS 8134.0. Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. At the time of the audit, there were nine residents with restraints (two lap belts and seven bed rails) and four residents using an enabler (all bed rails). Enablers are assessed as required, for maintaining safety and independence and are used voluntarily by the residents. The files for the four residents with enablers showed that enabler use is voluntary. Staff received training on restraint minimisation in January 2018.</p>

## Specific results for criterion where corrective actions are required

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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
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## Specific results for criterion where a continuous improvement has been recorded

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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 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 unit is completed monthly and is reported to the infection control committee and quality meetings. Trends and analysis identify areas for improvement. The service has continued to maintain urinary tract infections (UTI) rates at the lower end of the benchmark indicator for rest home residents.</p>	<p>The service has continued to implement interventions for the prevention of UTIs including ongoing staff education, resident education and encouraging use of the sanitisers throughout the facility, adequate fluids especially over the hot summer months and good staff hand hygiene. This has resulted in maintaining an average of 2.3 UTIs over the last 16 months within the rest home. One peak above the 2.3 in May 2017 was identified as the same month as the norovirus outbreak. With continued proactive education and interventions, the service has continued to maintain this low level of UTIs with many consecutive months of one to three UTIs from October 2017 to April 2018.</p>

End of the report.