# Age Care Central Limited - Marire Rest Home

## 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 The DAA Group 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Age Care Central Limited

**Premises audited:** Marire Rest Home

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 12 March 2020 End date: 13 March 2020

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 23

# Executive summary of the audit

## Introduction

This section contains a summary of the auditors’ findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

* consumer rights
* organisational management
* continuum of service delivery (the provision of services)
* safe and appropriate environment
* restraint minimisation and safe practice
* infection prevention and control.

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

**Key to the indicators**

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained  |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

## General overview of the audit

Marire Rest Home is certified to provide residential care for up to 29 residents. The facility is operated by Age Care Central Limited and is managed by a chief executive. Residents and families spoke highly about the care provided.

This certification audit was undertaken to establish compliance with the Health and Disability Services Standards and the service’s contract with the District Health Board. The audit process included review of policies and procedures, review of residents’ and staff files, observations and interviews with residents, families, management, staff, a nurse practitioner and an allied health professional.

A continuous improvement rating has been awarded relating to the reduction of medication use.

There are no areas requiring improvement from this audit.

## Consumer rights

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

The Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (the Code) is made available to residents of Marire Rest Home. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

Marire Rest Home provides services that respect the choices, personal privacy, independence, individual needs and dignity of residents. Staff were observed to be interacting with residents in a respectful manner.

Care for residents who identify as Maori is guided by a comprehensive Māori health plan and related policies.

There was no evidence of abuse, neglect or discrimination, and staff understood and implemented related policies. Professional boundaries are maintained.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to formal interpreting services if required.

The service has linkages with a range of specialist health care providers, which contributes to ensuring services provided to residents are of an appropriate standard.

The nurse manager is responsible for the management of complaints and a complaints register is maintained. There have been no complaints investigated by the Health and Disability Commissioner since the previous audit.

## 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. |

Marire Rest Home is governed by a board of trustees who are responsible for the service provided. The business plan is currently under review. Quality and risk management systems are fully implemented at Marire Rest Home and include a mission statement, philosophy and goals. Systems are in place for monitoring the service, including regular reporting by the chief executive and the senior leadership team to the board.

The facility is managed by a chief executive who has been in the role for two months. The chief executive is supported by a nurse manager, a clinical manager and a clinical coordinator. The nurse manager is responsible for the oversight of the clinical service in the facility.

Quality and risk management systems are followed. There is an internal audit programme. Adverse events are documented electronically. Various staff, health and safety and resident meetings are held on a regular basis. The hazard register evidenced review and updating of risks and the addition of new risks.

Policies and procedures on human resources management were in place and processes were followed. An in-service education programme is provided and staff performance is monitored.

The documented rationale for determining staffing levels and skill mixes is based on best practice. Registered nurses are rostered on the morning shifts with support from senior registered nurses/managers. The senior leadership team plus the registered nurse on duty in the company’s sister facility nearby, are on call after hours.

Residents’ information is accurately recorded, securely stored and not accessible to unauthorised people. Up to date, legible and relevant residents’ records are maintained using integrated electronic and hard copy files.

## 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. |

Marire Rest Home works closely with the local Needs Assessment and Service Co-ordination Service, to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, relevant information is provided to the potential resident/family to facilitate the admission.

Residents’ needs are assessed by the multidisciplinary team on admission within the required timeframes. Shift handovers and communication sheets guide continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that arise. All residents’ files reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme is overseen by two diversional therapists and an activities assistant and provides residents with a variety of individual and group activities and maintains their links with the community. Two facility vans are available for outings.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using an electronic system. Medications are administered by registered nurses and care staff, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Policies guide food service delivery supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents verified overall satisfaction with meals.

## Safe and appropriate environment

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| --- | --- | --- |
| 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. |

A current building warrant of fitness was displayed. A preventative and reactive maintenance programme included equipment and electrical checks.

Residents’ bedrooms provide single accommodation with adequate personal space provided. Lounges, dining areas and alcoves are available. External areas are extensive with seating and shade provided.

An appropriate call bell system is available, and security and emergency systems are in place.

## Restraint minimisation and safe practice

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| --- | --- | --- |
| 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 clear policies and procedures that meet the requirements of the restraint minimisation and safe practice standard. Marire Rest Home is a restraint free environment. There were no residents using an enabler at the time of audit.

## Infection prevention and control

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

The infection prevention and control programme, led by an experienced and appropriately trained infection control coordinator, aims to prevent and manage infections. Specialist infection prevention and control advice is accessed from the district health board. The programme is reviewed annually.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken, analysed, trended, benchmarked and results reported through all levels of the organisation. Follow-up action is taken as and when required.

## Summary of attainment

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement****(CI)** | **Fully Attained****(FA)** | **Partially Attained Negligible Risk****(PA Negligible)** | **Partially Attained Low Risk****(PA Low)** | **Partially Attained Moderate Risk****(PA Moderate)** | **Partially Attained High Risk****(PA High)** | **Partially Attained Critical Risk****(PA Critical)** |
| **Standards** | 0 | 45 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 1 | 92 | 0 | 0 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service DeliveryConsumers receive services in accordance with consumer rights legislation. | FA | Marire Rest Home (Marire) has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers’ Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records. |
| Standard 1.1.10: Informed ConsentConsumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Nursing and care staff interviewed understand the principles and practice of informed consent. Informed consent policies provided relevant guidance to staff. Clinical files reviewed showed that informed consent had been gained appropriately using the organisation’s standard consent form including for photographs, outings, invasive procedures and collection of health information. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent were defined and documented where relevant in the resident’s file. Staff demonstrated their understanding by being able to explain situations when this may occur. Staff were observed to gain consent for day to day care on an ongoing basis. |
| Standard 1.1.11: Advocacy And SupportService providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters related to the Advocacy Service were also displayed in the facility, and additional brochures were available at reception. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.Staff were aware of how to access the Advocacy Service.  |
| Standard 1.1.12: Links With Family/Whānau And Other Community ResourcesConsumers are able to maintain links with their family/whānau and their community.  | FA | Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. The facility has unrestricted visiting hours and encourages visits from residents’ families and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff. |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | The complaints policy and associated forms meet the requirements of Right 10 of the Code of Health and Disability Services Consumers’ Rights (the Code). The information is provided to residents and families on admission and there was complaints information available at the main entrance. Three complaints have been received since the last audit and have been entered into the complaints register. The complaints were reviewed, and actions taken were documented and completed within the timeframes specified in the Code. Action plans reviewed evidenced any required follow up and improvements have been made where possible. The nurse manager (NM) is responsible for complaint management and follow up. Staff interviewed confirmed a sound understanding of the complaint process and what actions are required.There have been no complaint investigations by external agencies since the previous audit.  |
| Standard 1.1.2: Consumer Rights During Service DeliveryConsumers are informed of their rights. | FA | Interviews with residents and residents’ families verified they were made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussion with staff. The Code was displayed in common areas together with information on advocacy services, how to make a complaint and feedback forms.  |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And RespectConsumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | Residents and families confirmed that the services they receive from Marire is provided in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices. Staff understood the need to maintain privacy and were observed doing so throughout the audit, when attending to personal cares, ensuring residents’ information was held securely and privately, exchanging verbal information and during discussions with families and the Nurse Practitioner (NP). All residents have a private room.Residents are encouraged to maintain their independence by participating in community activities, regular outings to the local shops or areas of interest and participation in clubs of their choosing. Each plan included documentation related to the resident’s abilities, and strategies to maximise independence. Records reviewed confirmed that each resident’s individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan. Staff understood the service’s policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed by staff and training. |
| Standard 1.1.4: Recognition Of Māori Values And BeliefsConsumers 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. | FA | There were no residents at Marire on the day of audit, who identified as Maori. Interviews verified staff can support residents and staff who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau to Māori residents. There was a current Māori health plan developed which draws on the priorities set by the National Maori Health strategy and the Taranaki District Health Board’s (TDHB) Maori Health Strategy. One of the board members identifies as Maori and provides a direct link to the local iwi and to cultural advisors if required. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And BeliefsConsumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.  | FA | Residents of Marire verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident’s personal preferences required interventions and special needs were included in all care plans reviewed, for example, food likes and dislikes and attention to preferences around activities of daily living. A resident satisfaction questionnaire includes evaluation of how well residents’ cultural needs are met, and this supported that individual needs were being met. |
| Standard 1.1.7: DiscriminationConsumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. A NP also expressed satisfaction with the standard of services provided to residents. The induction process for staff includes education related to professional boundaries and expected behaviours. All registered nurses (RNs) have records of completion of the required training on professional boundaries. Staff are provided with a Code of Conduct as part of their individual employment contract. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.  |
| Standard 1.1.8: Good PracticeConsumers receive services of an appropriate standard. | FA | The service encourages and promotes good practice through evidence based policies, input from external specialist services and allied health professionals, for example, hospice/palliative care team, respiratory nurse specialist, nurse practitioner, wound care specialist, services for older people, and access to ongoing education for staff. The NP confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests. Staff reported they receive management support to attend conferences, access external education opportunities, access online training hubs and are provided with regular inservice training opportunities. All care staff at Marire have level two and above caregiver qualifications.Other examples of good practice observed during the audit included a commitment to ongoing improvement in the care provided, evidenced by an ongoing initiative aimed at a reduction in the number of falls. An initiative implemented to reduce the effects of polypharmacy in several residents is recognised as area of continuous improvement. |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents and family members stated they were kept well informed about any changes to their own or their relative’s status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents’ records reviewed. There was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which was supported by policies and procedures that meet the requirements of the Code. Interpreter services can be accessed via TDHB when required. Staff reported interpreter services were rarely required. |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The company board is made up of seven directors with various backgrounds. The business plan, currently under review, includes a philosophy and mission statement and sets out the goals that are reviewed by the board. The philosophy and mission statement are in an understandable form and were displayed throughout the facility. An organisational and reporting chart sets out the structure of the organisation.The chief executive (CE), nurse manager (NM) and financial manager (FM) present reports at the two monthly board meetings. Review of the reports and interview of the CE confirmed this. The senior leadership team meet weekly to discuss a variety of activities relating to provision of services at Marire. Interview of the CE and review of meeting minutes confirmed this.The facility is managed by a chief executive (CE) who has been in the position for two months. Prior to this role they were the service supervisor for seven years and continue to be responsible for the service. The CE reported being familiar with the role as they have worked closely with the outgoing CE. The CE reported they are booked to attend two management courses, attends the three-monthly leadership forums provided by the local DHB and has attended an aged care association forum in February 2020. The CE is based at a sister facility close by and reported they visit Marire at least three times a week. The CE reported they have at least daily contact with the staff.The management of clinical services is the responsibility of the nurse manager (NM) who has been in their role full time since January 2020. Prior to this, the NM job shared with another nurse manager. The annual practising certificate for the nurse manager was current. There was evidence in the NM’s file of attending forums and conferences to keep up to date. The NM along with the clinical coordinator are based at the sister facility nearby and are responsible for clinical oversight at Marire. Documentation evidenced the change in CE and the NM to a fulltime role has been notified to HealthCERT.Marire has a contract with the DHB for aged related residential care. Twenty-two residents were receiving care under this contract and there was one resident who is a boarder. |
| Standard 1.2.2: Service Management 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.  | FA | The CE reported when they are temporarily absent, the FM fills the role. When the NM is temporarily absent the clinical coordinator fills in. The two RNs rostered on are experienced aged care nurses. Support is also provided by the board. |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | Quality systems are well embedded at Marire. Service delivery is linked to quality and risk throughout a number of documents including health and safety, clinical, incident and accident and infection control. Quality and risk are managed via the senior leadership team, RN and the health and safety meetings. Resident, health and safety, RN, health care assistants and other staff meetings are held regularly and evidenced good reporting of clinical indicators, any trends and discussions around corrective actions. Meeting minutes reviewed were comprehensive with names of people responsible for any corrective actions, timeframes for completion and sign off. Any unfinished business is brought forward to the following meeting.The audit programme for 2019 and 2020 and completed audits were reviewed. Resident and family surveys for 2020 evidenced satisfaction with the service provided. Interviews of residents and families confirmed this.Quality data is entered electronically. Data is collated and analysed to identify any trends. Corrective actions are developed and implemented for deficits identified. Various graphs showing quality data trends are generated month by month.All documents are controlled. They are relevant to the scope and complexity of the service, reflected current accepted good practice, and referenced legislative requirements. Footers showed the currency of review. Staff receive alerts electronically and are encouraged to make comments while documents are in draft. Obsolete documents are archived electronically.Actual and potential risks are identified and documented in the hazard register, including risks associated with human resources management, legislative compliance, contractual risks and clinical risk and showed the actions put in place to minimise or eliminate risks. Newly found hazards are communicated to staff and residents as appropriate. Staff confirmed they understood what constituted a hazard and the process around reporting and documenting. |
| Standard 1.2.4: Adverse Event Reporting 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.  | FA | Staff document adverse, unplanned or untoward events electronically. The CE and NM review and sign off following corrective actions developed and implemented. Documentation reviewed and interviews of staff indicated appropriate management of adverse events. Residents’ files evidenced communication with families following adverse events involving the resident, or any change in a resident’s condition. Families interviewed confirmed they were confident of being advised in a timely manner, as need be, following any adverse event or change in their relative’s condition.Staff stated they are made aware of their essential notification responsibilities through job descriptions, policies and procedures, and professional codes of conduct. Review of staff files confirmed this. Policy and procedures comply with essential notification reporting. The CE advised there has been one essential notification made to an external agency since the previous audit. |
| Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.  | FA | Policies and procedures relating to human resources management are in place. Staff files included job descriptions which outline accountability, responsibilities and authority, employment agreements, references, completed orientation and police vetting.An orientation programme is provided. New health care assistants (HCA) are supported by a senior HCA who works alongside them as an initial ‘buddy’ and undertakes reviews of the HCAs progress. The NM and CC are responsible for the orientation of new RNs. Orientation for staff covers all essential components of the service provided.In-service education is provided for staff at least monthly and the programme covers all required topics. Staff attend the sessions with staff from the sister facility nearby. Documentation evidenced good attendance at all sessions. Specific topics relating to resident’s health status is discussed at handover and during staff meetings. Outside educators take sessions and RNs attend sessions at the local DHB. Competencies were current including medication management and restraint. Both RNs and the EN are interRAI trained and have current competencies. There is at least one staff member on each shift with a current first aid certificate.A New Zealand Qualification Authority education programme (Careerforce) is available for staff to complete and they are encouraged to do so. An external assessor is used and HCAs have attained level two, three and four. All staff have completed at least eight hours of ongoing training annually.Staff performance appraisals were current. Annual practising certificates were current for all staff and contractors who require them to practice.Staff confirmed they have completed an orientation, including competency assessments. Staff also confirmed their attendance at on-going in-service education and the currency of their performance appraisals. |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery. Staffing levels are reviewed constantly to meet the changing needs of residents and the layout of the physical environment. The senior leadership team and the RN on duty in the sister facility nearby are on call after hours. Care staff reported there is adequate staff available to complete the work allocated to them. Residents and families interviewed confirmed this.Observations and review of rosters confirmed adequate staff cover was provided, with staff replaced in any unplanned absence. The NM reported that, should there be a need where a change in residents’ health status requires this, part time staff cover extra hours and there is also a pool of casual staff to call on. Staff who have a current first aid certificate are identified on the rosters. The senior managers are all experienced RNs and the two RNs and the EN on the floor all have many years’ experience working in the aged care sector.  |
| Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident’s name, date of birth and National Health Index (NHI) number were used as the unique identifier on all residents’ information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents’ files sampled for review. Clinical notes were current and integrated with NP, GP and allied health service provider notes. Records were electronic and legible with the name and designation of the person making the entry identifiable.Archived records are held securely on site and are readily retrievable using a cataloguing system. Hard copy residents’ files are held for the required period before being destroyed. For the past three years all residents’ records are electronic.No personal or private resident information was on public display during the audit.Electronic records are stored in a secure portal. |
| Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | Residents are admitted to Marire after they have been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service as requiring the services Marire provides. Prospective residents and/or their families are encouraged to visit the facility prior to admission and meet with the RN, Nurse Manager (NM), Clinical Co-ordinator (CC) or the Clinical Manager (CM). They are also provided with written information about the service and the admission process.Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.  | FA | Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the TDHBs ‘yellow envelope’ system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family. At the time of transition between services, appropriate information, including medication records and the care plan was provided for the ongoing management of the resident. All referrals were documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed transfer was managed in a planned and co-ordinated manner. Family of the resident reported being kept well informed during the transfer of their relative. |
| 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 | The medication management policy was current and identified all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by an RN against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request. Controlled drugs, when in use and on site, were stored securely in accordance with requirements. Controlled drugs were checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range. Good prescribing practices noted include the prescriber’s signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review was consistently recorded on the electronic medicine chart. There were no residents who were self-administering medications at the time of audit. Appropriate processes were in place to ensure this is managed in a safe manner if required. Medication errors are reported to the RN and NM, CC, CM and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified. Standing orders are not used. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | The food service is provided on site by a cook and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns was reviewed by a qualified dietitian in July 2018. Recommendations made at that time have been implemented. A food control plan is in place and registered with the Stratford District Council. A verification audit of the food control plan was undertaken 11 February 2020. No areas requiring corrective action were identifiedAll aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident’s nutritional needs was available.Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and residents’ meeting minutes. Any areas of dissatisfaction were promptly responded to. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There was enough staff on duty in the dining rooms at mealtimes to ensure appropriate assistance was available to residents as needed. |
| Standard 1.3.2: Declining Referral/Entry To Services 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.  | FA | If a referral is received, but the prospective resident does not meet the entry criteria or there is no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed with the CC. There is a clause in the access agreement related to when a resident’s placement can be terminated. |
| Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | On admission, residents of Marire are initially assessed using a range of nursing assessment tools, such as a pain scale, falls risk, skin integrity, nutritional screening and depression scale, to identify any deficits and to inform initial care planning. Within three weeks of admission residents are assessed using the interRAI assessment tool, to inform long term care planning. Reassessment using the interRAI assessment tool, in conjunction with additional assessment data, occurs every six months or more frequently as residents changing conditions require.In all files reviewed initial assessments were completed as per the policy and within 24 hours of admission. InterRAI assessments were completed within three weeks of admission and at least every six months unless the resident’s condition changed (refer 1.3.3). Interviews, documentation and observation verified the RNs were familiar with requirement for reassessment of a resident using the interRAI assessment tool when a resident had increasing or changing need levels. All residents have current interRAI assessments completed by three trained interRAI assessors on site. InterRAI assessments were used to inform the care plan. |
| Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. In particular, the needs identified by the interRAI assessments were reflected in the care plans reviewed.Care plans evidenced service integration with progress notes, activities notes, medical and allied health professional’s notations clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.  |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Documentation, observations and interviews verified the provision of care to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident’s individualised needs was evident in all areas of service provision. The NP interviewed, verified that medical input was sought in a timely manner, that medical orders were followed, and care was of a high standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents’ needs. |
| Standard 1.3.7: Planned ActivitiesWhere 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. | FA | The activities programme is provided by two trained diversional therapists and an activities assistant. A social assessment and history are undertaken on admission to ascertain residents’ needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident’s activity needs are evaluated regularly and as part of the formal three/six monthly care plan review. The planned monthly activities programme sighted matched the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents’ goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Examples included exercise sessions, daily walks, picnic, buggy rides, inter home competitions, sports days, men’s shed, visiting entertainers, quiz sessions and daily news updates. Individual residents have a range of individualised needs addressed. One resident is enabled to care for the gardens, build wooden items of interest to sell and provide some additional income. Residents with an interest in stock cars are supported to attend local meetings in addition to residents being supported to attend rugby games. The activities programme is discussed at the residents’ meetings and minutes indicated residents’ input was sought and responded to. Resident and family satisfaction surveys demonstrated satisfaction and that information is used to improve the range of activities offered. Residents interviewed confirmed they found the programme met their needs.The resident under 65 years has specific activities provided in line with the resident’s need and interest.  |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN. Formal care plan evaluations occurred every six months in conjunction with the six-monthly interRAI reassessment or as residents’ needs change. Evaluations were documented by the RN. Where progress was different from expected, the service responded by initiating changes to the plan of care. Examples were sighted of short-term care plans being initiated for infections, pain, weight loss, and medication changes. Progress was evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans, were evaluated each time the dressing was changed. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.  | FA | Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a main medical provider, residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the NP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents’ files. Referrals were followed up on a regular basis by the RN or the NP. The resident and the family were kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | Documented processes for the management of waste and hazardous substances were in place. Policies and procedures specify labelling requirements in line with legislation. Material safety data sheets were throughout the facility and accessible for staff. The company representative that supplies chemicals, visits regularly and provides training. Education to ensure safe and appropriate handling of waste and hazardous substances has been provided to staff. There was protective clothing and equipment appropriate to recognised risks and this was sighted in the sluice rooms and the laundry and were being used by staff. Staff demonstrated a sound knowledge of the processes relating to the management of waste and hazardous substances. |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness was displayed at the main entrance. There are appropriate systems in place to ensure the residents’ physical environment and facilities are fit for purpose. Residents and families stated they can move freely around the facility and that the accommodation met their needs. A proactive maintenance programme is in place and a reactive maintenance book for staff to enter any maintenance required has corrective actions completed and signed off. Plant and equipment were maintained to an adequate standard. Testing and tagging of equipment and calibration of biomedical equipment was current. Hot water temperatures were within the recommended range.Care staff confirmed they have access to appropriate equipment, that equipment was checked before use and they were competent to use it.Residents and families confirmed they know the processes they should follow if any repairs/maintenance are required and that requests are appropriately actioned.Extensive external areas are available that are safely maintained and are appropriate to the resident group and setting. All ramps have safety railing provided. The environment is conducive to the range of activities undertaken in the areas. Gardens were well maintained with several residents who are interested, managing vegetable and flower gardens. |
| Standard 1.4.3: Toilet, Shower, And Bathing FacilitiesConsumers 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. | FA | Four bedrooms have a full ensuite and some rooms have a wash hand basin. There are adequate numbers of communal bathrooms and toilets throughout the facility. Residents reported that there are enough toilets and they are easy to access with vacant/engaged signage.Appropriately secured and approved handrails are provided, and other equipment is available to promote resident’s independence. |
| Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.  | FA | Bedrooms provide single accommodation with a mix of sizes. There is adequate personal space provided for residents and staff to move around safely within the bedrooms. Residents and families spoke positively about their or their relative’s accommodation. Rooms are personalised with furnishings, photos and other personal adornments. There was room to store mobility aids such as mobility scooters and wheelchairs for those residents who require them. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And DiningConsumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There are various areas for residents and families to frequent for activities, dining, relaxing and for privacy. The areas are easily accessed by residents and staff. Residents and families confirmed this. Furniture was appropriate to the setting and arranged in a manner which enabled residents to mobilise freely. |
| Standard 1.4.6: Cleaning And Laundry ServicesConsumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | All laundry is washed on site. Residents and families reported the laundry was managed well and residents’ clothes were returned in a timely manner. Cleaners and laundry staff have received appropriate education and demonstrated a sound knowledge of processes. The facility was cleaned to a high standard and residents, families and the results from the 2020 satisfaction survey confirmed this. Chemicals are stored securely with a closed system used. All chemicals were in appropriately labelled containers. Cleaning and laundry processes are monitored through the internal audit programme and by personnel from the external company that supplies the chemicals. |
| Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations. | FA | Documented systems were in place for essential, emergency and security services. All external doors are locked at night and staff carry out regular security checks.A New Zealand Fire Service letter approving the fire evacuation scheme was sighted. Trial evacuations are held at least six monthly and staff have received on-going training. At least one staff member is on each shift who has a current first aid certificate. Review of staff education spread sheets and rosters confirmed this.Information in relation to emergency and security situations was readily available/displayed for service providers and residents. Emergency supplies and equipment are checked six monthly by the maintenance person and good stocks of supplies were sighted. Emergency supplies and equipment included lighting, torches, gas for cooking, extra food supplies, emergency water supplies that meet the Ministry of Civil Defence and Emergency Management recommendations for the region, and blankets, cell phones and battery powered emergency lighting.A call bell system is in place that is used by the residents or staff to summon assistance if required and is appropriate to the resident groups and settings. Call bells were accessible/within reach and were available in resident areas. Residents confirmed they have a call bell system in place which was accessible and that staff responded to them in a timely manner. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | The facility is heated by water filled radiators, underfloor heating and electric heaters. Procedures are in place to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Residents and families confirmed the facility was maintained at an appropriate temperature. Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.A covered area outside the building is available for smokers. |
| Standard 3.1: Infection control managementThere is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.  | FA | Marire provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, developed at organisational level with input from the Infection Control Co-ordinator (ICC). The infection control programme and manual have been reviewed annually. The RN with input from the NM, CC and CM is the designated ICC, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the NM, CC, and CM and tabled at the staff and board meetings. Infection control statistics are entered in the organisation’s electronic database and benchmarked with previous years statistics.Signage at the main entrance to the facility requests anyone who is, or has been unwell, has been overseas to countries with COVID-19 or in contact with people who have been in countries with COVID-19 not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities. |
| Standard 3.2: Implementing the infection control programmeThere are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The ICC has appropriate skills, knowledge and qualifications for the role; however, has been in this role for only a short time and is being assisted by the NM, CC and CM. The ICC has undertaken training in infection prevention and control and attended relevant study days, as verified in training records sighted. Well-established local networks with the infection control team at the DHB are available and expert advice from an external advisory organisation is available if additional support/information is required. The coordinator has access to residents’ records and diagnostic results to ensure timely treatment and resolution of any infections.The ICC confirmed the availability of resources to support the programme and any outbreak of an infection. |
| Standard 3.3: Policies and proceduresDocumented 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. | FA | The IPC policies reflected the requirements of the IPC standard and current accepted good practice. Policies were reviewed within the last year and included appropriate referencing. Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves, as was appropriate to the setting. Hand washing and sanitiser dispensers were readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.  |
| Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation and documentation verified staff have received education in IPC at orientation and ongoing education sessions. Education is provided by suitably qualified RNs and the ICN. Content of the training was documented and evaluated to ensure it was relevant, current and understood. A record of attendance was maintained. When an infection outbreak or an increase in infection incidence has occurred, there was evidence that additional staff education had been provided in response. An example of this occurred when there was a recent increase in urinary tract infections. Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell and increasing fluids during hot weather. |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and skin infections. When an infection is identified, a record of this is documented in the resident’s clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs. The ICC, NM, CC, and CM review all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via quality and staff meetings and at staff handovers. Surveillance data is entered in the organisation’s electronic infection database. Graphs are produced that identify trends for the current year, and comparisons against previous years. Data is benchmarked internally. Up until the day of audit there has been only three infections recorded at Marire. |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | Marire is a restraint free environment. The CE and NM reported they believe restraint has never been required. Equipment used included sensor and landing mats and sensors at the external doors. There were no residents using an enabler during the audit. The restraint coordinator demonstrated good knowledge relating to restraint minimisation. A restraint/enabler register is available if needed. Policies and procedures have definitions of restraints and enablers. Staff demonstrated good knowledge about restraints and enablers and knew the difference between the two.  |

# 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.

|  |
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| No data to display |

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

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

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

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 1.1.8.1The service provides an environment that encourages good practice, which should include evidence-based practice. | CI | The clinical teams attended a study day on polypharmacy and the effects of polypharmacy on residents. Following this, five residents at Marire who were identified as a high falls risk, observed to be unsteady on their feet, had numerous incidents of near misses, and evidence of compromised independence and mobility had their medications reviewed in consultation with the resident, their families, the staff and the NP. The aim was to identify possible opportunities that some medications were no longer required and could be reduced or stopped in order to improve the resident’s quality of life. Over a six-month timeframe (Sept 2019 to March 2020) gradual changes to medication were made, with some medications being stopped, doses reduced or changed. When a medication was stopped, it was charted as a backup pro re nata (PRN) dose for two weeks to provide the resident with some security in case it was needed. All five residents had at least one medication deemed unnecessary and stopped. All five residents have improved with a reduction in falls, increased alertness and responsiveness. In addition to the reduction in medication, there was increased activity sessions provided to improve mobility, strength, muscle tone and stimulation. Four of the five residents no longer require sleeping pills at night, while the other resident has had a reduction in an anti-anxiety medication. Family members of residents and residents themselves interviewed, expressed a high degree of satisfaction with how they were feeling with the reduction in medication. Medication reviews remain ongoing at Marire. | The reduction in the use of medication by five residents at Marire has resulted in improvements in quality of life for the residents. |

End of the report.