# Molly Ryan Lifecare (2007) Limited - Molly Ryan Lifecare and Retirement Village

## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](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:** Molly Ryan Lifecare (2007) Limited

**Premises audited:** Molly Ryan Lifecare and Retirement Village

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

**Dates of audit:** Start date: 25 January 2022 End date: 26 January 2022

**Proposed changes to current services (if any):**  No

**Total beds occupied across all premises included in the audit on the first day of the audit:** 36

# 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

Molly Ryan Lifecare is part of the Arvida Group. The service is certified to provide rest home and hospital level care for 33 residents and up to a further 28 residents requiring rest home level care in studio apartments. At the time of the audit there were 36 residents, including five rest home residents in the studio apartments.

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

An experienced village manager manages the service with support from an experienced clinical manager and a national quality manager. Family and residents interviewed all spoke positively about the care and support provided. There are systems, processes, policies and procedures that are structured to provide appropriate care for residents. Implementation is being supported through the organisation’s quality and risk management programme.

There were no shortfalls identified at this audit.

## Consumer rights

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

Policies and procedures adhere with the requirements of the Code of Health and Disability Services Consumers’ Rights (the Code). Residents and families are informed regarding the Code and staff receive ongoing training about the Code.

The personal privacy and values of residents are respected. There is a Māori health plan in place. Individual care plans reference the cultural needs of residents. Discussions with residents and relatives confirmed that residents and where appropriate their families, are involved in care decisions. Regular contact is maintained with families including if a resident is involved in an incident or has a change in their current health. Families and friends are able to visit residents at times that meet their needs (noting Covid-19 restrictions in place as per national guidelines).

There is an established system for the management of complaints, which meets guidelines established by the Health and Disability Commissioner.

## 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. |

Molly Ryan Lifecare has a current strategic plan and a quality assurance and risk management programme that outlines objectives for the next year. Services are planned, coordinated and are appropriate to the needs of the residents. Goals are documented for the service with evidence of regular reviews. A documented quality and risk management programme is embedded in practice. Corrective actions are implemented and evaluated where opportunities for improvements are identified.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. An education and training plan is being implemented and includes in-service education and competency assessments.

Registered nursing cover is provided 24 hours a day, seven days a week. The resident files are appropriate to the service type.

## Continuum of service delivery

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

There is an admission package available to residents and families prior to or on entry to the service. The registered nurse assesses, plans, reviews and evaluates residents' needs, outcomes, and goals with the resident and/or family/whānau input and are responsible for each stage of service provision. The electronic care plans demonstrate service integration; there is a plan in place for registered nurses to review assessments and care plans at least six-monthly. Resident files are electronic and included medical notes by the general practitioner, and allied health professionals.

The wellness team provides and implements a wide variety of activities which include cultural celebrations. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical, cultural, and cognitive abilities and resident preferences. Residents are supported to maintain links within the community.

Medication policies reflect legislative requirements and guidelines. The registered nurses and wellness partners are responsible for administration of medications and have completed education and medication competencies. The electronic medicine charts reviewed met prescribing requirements and were reviewed at least three-monthly by the general practitioner. Medications are stored securely.

All food and baking are prepared and cooked on site in the centrally located kitchen. Residents' food preferences and dietary requirements are identified at admission. There is a spacious dining room. The menu has been reviewed by a dietitian and meet the required nutritional values. Alternatives are available for residents. A current food control plan has been registered.

## 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 building has a code of compliance, which expires on 16 April 2022. There is a planned and reactive maintenance programme in place. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating, and shade. Resident rooms are spacious and personalised, all have full en-suites.

Emergency systems are in place in the event of a fire or external disaster. There is always a staff member on duty with a current first aid certificate. There are planned and implemented strategies for emergency management. Fire drills occur six-monthly.

There are dedicated housekeeping staff, who provide all cleaning and laundry duties. Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services.

## 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. |

Molly Ryan Lifecare has restraint minimisation and safe practice policies and procedures in place. Staff receive training around restraint minimisation and the management of challenging behaviour. On the days of the audit there was one resident with a restraint and no enablers used.

## 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. |

A suite of infection control policies and procedures are documented. The infection control programme is appropriate for the size and complexity of the service. All policies, procedures, the pandemic plan, and the infection control programme have been developed and approved at organisational level.

The infection control coordinator is a registered nurse. Surveillance data is undertaken. Infection incidents are collected and analysed for trends and the information used to identify opportunities for improvements. Internal benchmarking within the organisation occurs. Staff are informed about infection control practises through meetings, and education sessions. Benchmarking occurs for infections. There was one outbreak in August 2021 which was managed appropriately.

## Summary of attainment

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement****(CI)** | **Fully Attained****(FA)** | **Partially Attained Negligible Risk****(PA Negligible)** | **Partially Attained Low Risk****(PA Low)** | **Partially Attained Moderate Risk****(PA Moderate)** | **Partially Attained High Risk****(PA High)** | **Partially Attained Critical Risk****(PA Critical)** |
| **Standards** | 1 | 49 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 1 | 100 | 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 | Discussions with staff (one kaumātua, three wellness partners (caregivers), one registered nurse (RN), kitchen manager, one laundry staff/wellness partner, one clinical administrator/wellness leader (enrolled nurse), two wellness partners/activities, Māori health consultant), along with the managers (village manager, clinical manager, national quality manager) confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers’ Rights (the Code). Seven residents (four rest home and three hospital level) and six relatives (four hospital and two rest home) were interviewed and confirmed the services being provided are in line with the Code. Observation during the audit confirmed this in practice. |
| 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 | Informed consent and advance directive policies are in place and include responsibilities and guidance to staff. Discussions with the wellness partners and registered nurses confirmed that staff understand the importance of obtaining informed consent for providing personal care and accessing residents’ rooms.Informed consent processes are discussed with residents and families on admission. Written general consents for photographs, release of medical information, and medical cares were signed as part of the admission agreement. Indemnity and outing consent are scanned into the resident electronic file. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation’s standard consent form including the offering of the flu and Covid-19 vaccines. Advance care planning, establishing, and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and was documented, as relevant, in the residents’ records. Staff were observed to gain consent for day-to-day care.The service welcomes the involvement of family/whānau in decision making where the person receiving services wants them to be involved. Training has been provided to staff around code of rights, informed consent and enduring power of attorney (EPOAs) in 2021.  |
| Standard 1.1.11: Advocacy And SupportService providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | A policy describes access to advocacy services. Staff receive training on advocacy, last occurring in 2021. Information about accessing advocacy services information is available in the entrance foyer. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Advocate support is available if requested. Interviews with staff and residents informed they are aware of advocacy and how to access an advocate. |
| 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 encouraged to be involved in community activities and maintain family and friends’ networks. On interview, staff stated that residents are encouraged to build and maintain relationships. Staff receive training on advocacy during induction and through the online education platform. All residents and relatives interviewed confirmed that relative/family visiting could occur at any time noting the Covid-19 restrictions when these are in place. Current Covid guidelines allow fully vaccinated visitors in the facility. Residents are supported to maintain links with community groups as able, pet therapy groups, church groups and entertainers visit the facility. Due to current guidelines, no school groups are able to visit.  |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | 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. Complaint forms are available at each entrance of the households. Staff are aware of the complaints process and to whom they should direct complaints. A complaints register is available. There have been two complaints in 2020, one in 2021 and none in 2022 year to date. The complaints reviewed have been managed appropriately with acknowledgement, investigation and response recorded. Residents and relatives interviewed advised that they are aware of the complaints procedure and how to access forms. The residents interviewed felt comfortable discussing concerns with either a registered nurse or the management team. There has been one complaint from the Health and Disability Commissioner (HDC) in 2019. Recommendations made by HDC have been addressed including those related to medication management and administration. This complaint has been closed out by the HDC. |
| Standard 1.1.2: Consumer Rights During Service DeliveryConsumers are informed of their rights. | FA | There are posters of the Code on display throughout the facility and leaflets are available in the foyer of the facility. The service is able to provide information in different languages and/or in large print if requested. Information is also given to next of kin or enduring power of attorney (EPOA) to read with the resident and discuss. On entry to the service, the village manager or clinical manager discusses the information pack with the resident and the family/whānau. The information pack incudes a copy of the Code. |
| 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 | Staff interviewed could describe the procedures for maintaining confidentiality of resident records, residents’ privacy, and dignity. House rules and a code of conduct are signed by staff at commencement of employment. Residents and relatives interviewed reported that residents can choose to engage in activities and access community resources. There is an elder abuse and neglect policy and staff education and training on abuse and neglect has been provided.  |
| 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 | The organisation has established cultural policies to help meet the cultural needs of its residents. There was one resident who identified as Māori at the time of the audit. The service has contracted a Māori consultant who is helping the organisation to further develop the Māori Health plan and to implement strategies when developed. The Māori Health consultant was interviewed and confirmed their role. They acknowledged the organisational drive to develop services more to be appropriate and offer equitable services for Māori. The service also links with the DHB if required for advice and support. Molly Ryan has a longstanding relationship with a local kaumātua, who is available to provide advice or guidance at any time. The kaumātua confirmed their engagement in reviewing policies and practices as they relate to Taranaki. Cultural and spiritual practice for Māori residents is supported and identified needs are incorporated into the care planning process and review as demonstrated in the resident file sampled. Discussions with staff confirmed that they are aware of the need to respond to cultural differences.  |
| 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 | The service has established cultural policies aimed at helping meet the cultural needs of its residents. Residents interviewed reported that they were satisfied that their cultural and individual values were being met. Information gathered during assessment including resident’s cultural beliefs and values, is used to develop a care plan, which the resident (if appropriate) and/or their family/whānau are asked to consult on. Staff receive training on cultural awareness, last occurring in 2021. Wellness partners interviewed described getting to know each individual resident’s preferences and learning about resident’s values and beliefs. |
| Standard 1.1.7: DiscriminationConsumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Arvida has an organisational staff code of conduct, which states there will be zero tolerance against any discrimination occurring. The abuse and neglect processes cover harassment and exploitation. Residents interviewed reported that the staff respected them. Staff and the GP stated that there was no evidence of abuse or neglect. Professional boundaries are reconfirmed through education and training sessions, staff meetings, and performance management if there were to be an infringement with the person concerned. Residents interviewed felt that they were not exposed to exploitationJob descriptions include responsibilities of the position, ethics, advocacy, and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct. |
| Standard 1.1.8: Good PracticeConsumers receive services of an appropriate standard. | CI | The service has policies to guide practice that align with the Health and Disability Services Standards, for residents with aged care needs. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. Residents and families interviewed spoke very positively about the care and support provided. Staff interviewed had a sound understanding of principles of aged care and stated that they feel supported by the management team. All staff are embracing the ‘Attitude of Living Well’ model of care. The general practitioner visits weekly. The physiotherapist visits once a week to assess all new residents and as required during the week. The podiatrist visits regularly. The organisation has included the required dementia standards in the Level 4 New Zealand Qualification Authority (NZQA) provided through Careerforce training. The service encourages all staff to complete NZQA qualifications. The service has been awarded a continuous improvement around falls prevention.  |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents interviewed stated they were welcomed on entry and given time and explanation about the services and procedures. 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. Sixteen incident/accident forms reviewed for December 2021 and January to date had documented evidence of family notification or noted if family did not wish to be informed. Relatives interviewed confirmed that they are notified of any changes in their family member’s health status. Residents interviewed stated that they were welcomed on entry and were given time and explanation about the services and procedures. Interpreter services are available as required.  |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Molly Ryan Lifecare is part of the Arvida Group. Molly Ryan Lifecare is certified to provide rest home and hospital (geriatric and medical) for up to 61 residents across the rest home and studio apartments. There are 33 care home beds which are all dual-purpose. There are 28 studio apartments. Twenty-three apartments are certified for rest home or retirement village residents and five are certified for either rest home or hospital residents. Occupancy on the day of audit was 36 residents (22 rest home and 14 hospital residents. There were four residents in the studio apartment area requiring rest home level of care and one in a studio apartment requiring hospital level of care). There were no residents on respite. There is a village manager who has been in the role since July 2017 and who has 37 years’ experience in aged care. The village manager is supported by an experienced clinical manager who has been in the position for a year, and in the aged care industry for over 12 years. The village manager and clinical manager are supported by the national quality manager (registered nurse who was present on the days of the audit) who has been in the role for over four years.The village manager provides a monthly report to the Arvida CEO on a variety of operational issues. Arvida has an overall business/strategic plan. The organisation has a philosophy of care, which includes a mission statement. Molly Ryan has a business plan for 2021 and 2022 and an annual quality and risk management programme with progress against objectives documented. Monthly meetings include the networking clinical manager meetings. There are annual village manager forums and clinical manager forums. The village manager and clinical manager have completed in excess of eight hours of professional development in the past 12 months. |
| 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 | In the absence of the village manager, the clinical manager is in charge. Support is provided by the general manager wellness and care, and the team at the support office.  |
| 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 | There is an organisational quality and risk management system in place at Molly Ryan which is designed to monitor contractual and standards compliance. There is a 2022 business/strategic plan that includes quality goals and risk management plans for the service. 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. The Arvida Group policies are reviewed at least every two years across the group. Head office sends new/updated policies. Data is collected in relation to a variety of quality activities and an internal audit schedule is implemented with evidence of corrective action plans documented when issues arise and sign off of resolution against the corrective action plan. Areas of non-compliance identified through other quality activities are actioned for improvement. There are regular meetings where data and improvements are discussed. These include three monthly staff meetings, monthly quality meetings, monthly health and safety, monthly registered nurse meetings and three-monthly resident/family meetings which include residents from the studio apartments if they are identified as receiving care. There are also household meetings. The management meeting is held weekly and includes the village and clinical managers. This supports ongoing day-to-day operational needs. Interviews with staff confirmed that there is discussion about quality data at various meetings.The service has a health and safety management system that is regularly reviewed. Restraint and enabler use is reviewed within the quality and clinical staff meetings. Data is collected in 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 overall service result for the resident/relative satisfaction survey completed in March 2021 was a net promoting score of 43. Three aspects of the service rated greater than 80% with respondents very satisfied with safety and security, care staff and cleaning. A corrective action around food services was put in place and a review of the corrective action plan showed that the issues had been resolved with a high level of resident satisfaction as a result of the actions put in place. Residents/relatives are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families. The benchmarking data collated by the wellness and care team is reviewed within that team on a monthly basis. The information is forwarded to each village, in pdf format, with a summary provided. Steering groups have been set up (with voluntary membership from various clinical managers or interested staff) which are facilitated by a wellness and care team member. In addition, there is external benchmarking with other providers on clinical key performance indicators. The national quality manager ensures the internal audits are current. Each audit has a risk-based assessment process, and an escalation plan if a high risk is determined. Health and safety goals are established and regularly reviewed. Risk management, hazard control and emergency policies and procedures are being implemented and are monitored by the Health and Safety Committee. Hazard identification forms and a hazard register are in place. 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. The Arvida health and safety programme is overseen by a health and safety manager at support office. There is a virtual monthly Arvida health and safety meeting, facilitated by the health and safety manager, and this includes participants from every Arvida village. There is opportunity for open discussion at this meeting. The health and safety representative on site is the maintenance staff. |
| 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 | 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 shift handovers. An RN conducts clinical follow-up of residents. Incident forms reviewed demonstrated that appropriate clinical follow-up and investigation occurred following incidents and family notifications were documented. Neurological observation forms were fully completed as per policy for 11 incidents with unwitnessed falls or potential head injuries. 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. Notifications were sent from the support office for RN staffing and a police investigation. A respiratory outbreak in August 2021 was managed in conjunction with Public Health.  |
| 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 | There are human resource management policies in place. This includes that the recruitment and staff selection process require that relevant checks are completed to validate the individual’s qualifications, experience and veracity. Nine staff files were reviewed (one clinical manager, three RNs, three wellness partners, one clinical administrator/wellness leader, one kitchenhand/cleaner). There is evidence that reference checks were completed before employment was offered. Annual staff appraisals were evident in all staff files reviewed. A copy of practising certificates is kept on record. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Completed orientation is on files and staff described the orientation programme. New staff interviewed confirmed that they had completed a full orientation that included reading relevant policies and procedures and being buddy with a senior staff member until they were ready to work alone. The in-service education programme for 2021 has been completed and the plan for 2022 is being implemented. The village manager, clinical manager and RNs are able to attend external training, including sessions provided by the local district health board (DHB). Discussions with the wellness partners 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 five RNs and the clinical manager. Four RNs have completed interRAI training along with the clinical manager. Wellness partners work to achieve NZQA certificates. All have progressed through to level two, three or four except for new staff who have been in the service for less than three months. Staff interviewed had all completed level three or level four.  |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | Molly Ryan Lifecare policy includes staff rationale and skill mix. Sufficient staff are rostered on to manage the care requirements of the residents. The service has a total of 60 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 at least one RN on at any one time. The RN on each shift is aware that extra staff can be called on for increased resident requirements. Interviews with staff, residents and family members confirmed there are sufficient staff to meet the needs of residents. At the time of the audit, there were 20 rest home residents and 13 hospital residents in the care home. There is one RN on the morning and afternoon shifts, and one on night duty. The RNs are supported by five caregivers rostered on the morning, four caregivers on the afternoon shift and one caregiver on night duty. This roster is adjusted as hospital residents are admitted with general ratios of 1:5 for hospital level residents and 1:10 for rest home residents or a combination as resident needs dictate. There are three rest home residents in the studio apartments and there is one caregiver servicing them on the morning shift. The caregivers in the care home supervise the rest home level care residents in the studio apartments on the afternoon and night shifts.  |
| Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. Residents' electronic files are protected from unauthorised access by individual passwords. Other residents or members of the public cannot view sensitive resident information. Entries in records are legible, dated and electronically signed with designation by the relevant staff member entering the information in the electronic system.  |
| 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 who are admitted to the service have been assessed by the needs assessment service coordination (NASC) service to determine the required level of care. The village manager and clinical manager screen prospective residents. The entry to service policy/decline to entry policy and procedure guide staff around admission and declining processes including required documentation, intervals for communication to ensure timely response to whānau and other providers. Routine demographic data is collated including ethnicity data to improve information on the decline process. The village manager generates an electronic monthly report identifying prospective residents and families who already viewed the facility, admissions and declined referrals. The service receives referrals from the needs assessment service coordination (NASC) service, the DHB, Hospice and directly from residents or whānau. The service has an information pack relating to the services provided at Molly Ryan which is available for families/whānau and residents prior to admission or on entry to the service and kept in the resident room. Six admission agreements reviewed were signed and aligned with contractual requirements. Exclusions from the service are included in the admission agreement.  |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.  | FA | The transfer and discharge of resident management policy ensures a smooth, safe, and well organised transfer or discharge of residents. The registered nurses interviewed described exits, discharges or transfers are coordinated in collaboration with the resident and whānau to ensure continuity of care. There was evidence that residents and their families were involved for all exits or discharges to and from the service and have the opportunity to ask questions. A transfer report is completed and includes a copy of the advance directives, advance care plan (where available and medication chart. A verbal handover is provided. Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Discussion with the registered nurses identified that the service accesses support either through the GP, specialists, and allied health services as required. There is evidence of referrals for re-assessment from hospital level of care to hospital specialised dementia level of care. |
| 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. Medications are stored safely in a locked medication/treatment room. Clinical staff who administer medications (RNs and wellness partners) have been assessed for competency on an annual basis and attend annual medication education. Regular medication management internal audits are completed to measure compliance. All medication errors are reported and collated within the quality data and corrective actions are completed in a timely manner and will include a reassessment of competencies where required. Registered nurses have completed syringe driver training. All medication (robotic rolls) is checked on delivery against the electronic medication charts by one RN and one wellness partner (night staff). Weekly checks of extra medications (non-blister packed medications including inhalers and creams) held in the treatment room has been performed weekly to ensure there is no expired medication in stock. There were no self-medicating residents. The medication fridge and room temperatures are recorded daily and were within expected ranges. There were no standing orders. Eyedrops and ointments are dated when first opened. Controlled entries align with medication chart, entries are fully completed and signed by two medication competent staff.Twelve electronic medication charts were reviewed and met prescribing requirements. Medication charts had photo identification and allergy status notified. The GP had reviewed the medication charts at least three-monthly. ‘As required’ medications had prescribed indications for use. Residents and relatives interviewed stated they are updated when medication changes, including the reason for changing medications and any side effects.  |
| 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 services are overseen by a kitchen manager (cook) and is supported by a weekend cook and two kitchen assistants. All food service staff that are involved in cooking have completed food safety training. There is a food control plan in place that expires on 14 June 2023. The four-weekly menu has been approved and reviewed by a registered dietitian on 25 November 2021. The kitchen manager (interviewed) receives resident dietary profiles and is notified of any dietary changes for residents. The residents have a nutritional profile developed on admission, which identifies dietary requirements, likes, and dislikes. The kitchen manager stated they cater for cultural preferences, adopt alternatives and special diets are accommodated, including high protein, low sodium, gluten free, diabetic desserts, and modified foods.The kitchen is centrally located near the main dining room, a smaller dining room is available for the serviced apartment residents. There is lift access near the main dining room for the residents’ upstairs. Meals are transported in a bain-marie and are served by a kitchen assistant. Thermal lid tray service is available for residents who choose to dine in their rooms. The dining areas are spacious and provide enough space for staff to assist residents with their meals and residents in mobile chairs. The menu is displayed in the dining room and residents can easily see what is on the menu for the day. Lunch was observed on the first day of the audit and the food was visually appealing. All perishable foods and dry goods were date labelled. A cleaning schedule is maintained, and chemicals are stored securely. Staff were observed to be wearing appropriate personal protective clothing. Freezer, fridge and end-cooked, reheating (as required), cooling and serving temperatures are taken and recorded daily. Food is probed for temperature when transferred to the to the bain-marie and served. The internal audit schedule and surveys include the food service. Corrective actions are implemented when required to improve the service. Residents interviewed stated they were satisfied with the food service and overall dining experience. Special equipment such as 'lipped plates' and built-up spoons are available as needs required. The satisfaction survey completed in February 2021 evidenced 3.23/5.0 for the quality of food. Residents and relatives interviewed were satisfied with the variety and dining experience. The kitchen manager is involved in the activities theme months, particularly during cultural events and celebrations. |
| 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 | In cases where entry is declined, there is close liaison between the service and the referral team. The service refers the potential resident back to the referrer and maintains data around the reason for declining. The management team described reasons for declining entry would only occur if the service could not provide the service the resident required, after considering staffing, equipment requirements, and the needs of the resident. The other reason would be if there were no beds available. The policy describes communication intervals to ensure timely response to whānau.Management communicates directly with the referring agencies and family/whānau as appropriate if entry was declined.  |
| Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | The RN completes an admission assessment including relevant risk assessment tools. Risk assessments are completed six-monthly or earlier due to health changes. InterRAI assessments and long-term care plans were completed within the required timeframes in six resident files reviewed. The outcomes of assessments are reflected in the needs and support required documented in the care plans on the electronic system. Behaviour assessments had been completed for one resident with known behaviours. Other available information such as discharge summaries, medical and allied health notes, and consultation with resident/relative or significant others form the basis of the long-term care plans.  |
| Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Resident care plans on the electronic system for all resident files reviewed were resident-focused and individualised. Support needs as assessed were included in the long-term care plans. The electronic programme identifies interventions that cover a comprehensive set of goals including managing medical needs/risks, daily activities of living, transferring and mobility, nutritional, behaviour support plans, cultural and spirituality plans, and leisure plans. Care plans were current and are updated with any changes to care or health status. Care plans include the involvement of allied health professionals involved in the care of residents in meeting their specific goals around wellbeing. Residents/relatives interviewed confirmed they were involved in the development of the long-term care plan. There was documented evidence of family involvement in the development of care plans. There was evidence of allied health care professionals involved in the care of the resident including podiatrist, dietitian, nutrition clinic, speech and language therapist, older persons mental health services, gastroenterology service, ophthalmology services, wound nurse, and hospice.  |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Residents and relatives interviewed reported their needs and expectations were being met. When a resident's condition alters, the registered nurse initiates a review and if required a GP/NP visit or nurse specialist consultant. Family was notified of all changes to health including infections, accident/incidents, GP visit, medication changes and any changes to health status. Electronic progress notes record family notifications and discussions.There were eleven wounds treated including skin tears and a chronic venous ulcer. There was one stage 2 pressure injury showed timely progression towards healing. The electronic wound care plan documents the wound management plan and evaluations are documented with supporting photographs and documented wound assessments showing progression towards healing. The district nurse and GP have input into chronic wound management. Wellness partners and RNs completed pressure injury prevention and management education in 2021 as part of the annual staff education. Wellness partners interviewed stated there are adequate clinical supplies and equipment provided including continence, wound care supplies and pressure injury prevention resources. A continence specialist can be accessed as required.Care plans reflect the required health monitoring interventions for individual residents and all monitoring was implemented as required. Wellness partners and RNs complete electronic monitoring charts including personal cares, bowel chart, blood pressure, weight, food and fluid chart, behaviour chart, blood sugar levels and toileting regime. Charts are regularly reviewed by the RN. Neurological observations had been completed and recorded for unwitnessed falls. Progress notes recorded continuity of care or changes in care for the sharing of information between care staff.  |
| 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 a wellness leader (works Monday to Friday) and two wellness partners (one a qualified diversional therapist) who provides activities from Monday to Sunday. Both the wellness leader and the wellness partners are involved in activities during the week. The service implemented the wellness model and the household model of care. Residents have input into the programme and activities are discussed at fortnightly resident meetings (household and community meeting). Residents and wellness partners interviewed advised that they enjoy the activities programme and that it is varied and entertaining. Residents stated that they were satisfied with the activities programme. The wellness team collates a social profile ‘about me’ of the resident in the electronic system and include relationships, cultural, spiritual, lifestyle routine and community links. A social and cultural individual care plan is developed on the information gathered. The RNs record information and include this into a long-term care plan. A cultural assessment is completed to inform Te Whare Tapa Whā and is visible throughout sections of the care plan. Residents are encouraged to use te reo Māori. There are monthly themes for example, Mat ariki, spring, gardening, Waitangi Day, and Christmas. The planner includes a list of suggestions for activities to include the five pillars of the Attitude of Living Well model (eating well, moving well, resting well, thinking well, and engaging well). The two lounges are spacious enough to provide group activities. The activities planner is set up with input from the residents. A weekly activities programme is provided to the residents in large print in their rooms and copies are displayed throughout the facility on the notice boards. Group activities include walking train, spin poi, baking, reading group, crafts, card bingo armchair travel, Zumba exercises, church services and entertainment. One-on-one activities include balloon tennis, making milkshakes, arranging flowers, and reading the newspaper, wheelchair walks, massage, shopping, manicures, reading, and sensory activitiesThe care plan includes spirituality and religious preferences. There is a Māori chaplain and weekly interdenominational chaplaincy service (volunteer) available to residents. The chaplain was available on the day to be interviewed and stated she had been involved with the service for the past 11 years and assists relatives and staff with bereavement support. The wellness team maintains attendance records and uses these to document progress notes. Cultural events include Māori related activities scheduled as part of the activities programme to celebrate cultural diversity and include celebrating Mat ariki, spinning poi and Māori sing along. Residents receive a copy of the monthly programme which has the daily activities displayed and includes individual and group activities. A separate copy of church service dates is provided with the activities programme.The wellness team endeavours to include previous hobbies and interests to the planner. Residents are assisted to maximise their potential for self-help and to maintain links with whānau and the community by supporting them to go out into the community. Safe transportation (designated drivers have a current first aid certificate) is provided to access and support community and external activities including visits to a café or scenic drives. There are established links with four community groups including Probus and external entertainers that provide weekly entertainment. Wellness partners stated they are involved in the six-monthly multidisciplinary (MDT) case conference meeting. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | All 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 RN six monthly for residents who had been at the service six months. Long-term care plans had been updated with any changes to health status following the multidisciplinary (MDT) case conference meeting. Family is invited to attend the MDT case conference meeting. If they are unable to attend the RN provides the opportunity for family to provide input by phone and they receive a copy of the care plan. Written case conference notes are kept on the electronic system and evidenced resident/relative input. Written evaluations reviewed, identified if the resident goals had been met or unmet. The GP reviews the residents at least three monthly or earlier if required. Ongoing RN evaluations occur as indicated and are documented within the electronic progress notes.  |
| 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 | The service facilitates access to other medical and non-medical services. Referral to other health and disability services is evident in the resident files reviewed. Referral documentation is maintained on resident files. Discussion with the clinical manager identified that the service has access to a wide range of support either through the GP, specialists, and allied health services as required. One resident had input from older mental health services and input from a psychogeriatrician. The resident waits for an assessment to a higher level of care. |
| 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 | There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer’s labels and stored in locked areas. Cleaning chemicals are dispensed through a pre-measured mixing unit or auto feed systems. Safety data sheets and product sheets are available. Sharp’s containers were available and meet the hazardous substances regulations for containers. Gloves, visors, and aprons are available for staff. There is a sluice tub located within the laundry. Personal protective equipment was available including a face visor/shield available. Staff have completed chemical safety training. A chemical provider monitors the effectiveness of chemicals.  |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The service employs a full-time maintenance manager who is on call after hours for maintenance issues. The maintenance manager ensures daily maintenance requests are addressed and a planned maintenance schedule is maintained. There is a comprehensive planned maintenance programme in place. Reactive and preventative maintenance occurs. Hot water temperatures have been monitored in resident areas and are within the acceptable range. Essential contractors are available 24 hours. An external contractor annually completes electrical testing. Electrical equipment has been tested and tagged. The hoist and scales are checked annually. The wellness partners and RNs interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans. The building has a current building warrant of fitness that expires 8 February 2022. Annual calibration and functional checks of medical equipment including hoists, oxygen concentrators weighing scales and the syringe driver is completed by an external contractor. The maintenance person completes regular visual and physical checks of transferring equipment, beds, and call bells. Hot water temperatures in resident areas are monitored monthly and are maintained within acceptable ranges. The care centre is situated on the ground floor and upstairs. The lift is spacious enough to accommodate ambulance transfer equipment. Flooring is safe and appropriate for residential care. All corridors have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas and courtyard areas are well maintained. All external areas have attractive features, including raised beds and planters. All outdoor areas have some seating and shade. There is safe access to all communal areas. There is a secure centrally located nurses’ office. There is safe access to all communal areas. There are two large, shared lounges with separate entrances. Two dining rooms on each side of the reception area. Doors to the laundry, kitchen and nurses’ station have signs with English and te reo Māori names. Serviced apartments are situated on the first floor with four upstairs.  |
| 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 | All resident rooms have a spacious en-suite shower/toilet with appropriately situated call bells and handrails. Toilets and shower facilities are of an appropriate size and design to meet the needs of the residents. There are communal toilets located near communal areas. Residents interviewed confirmed care staff respect the resident’s privacy when attending to their personal cares. There are communal bathrooms/showers within the facility with privacy locks and privacy curtains. Fixtures, fittings, and flooring are appropriate. There is sufficient space in toilet and shower areas to accommodate shower chairs if appropriate. There is a mobility toilet near the large main communal lounge. The visitors’ toilet has free flowing soap and an air dryer.  |
| 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 | All rooms are single. There is adequate room to safely manoeuvre mobility aids and transferring equipment such as hoists in the resident bedrooms within the care facility. Residents and families are encouraged to personalise bedrooms. A tour of the facility evidenced personalised rooms including the residents own furnishing and adornments. Serviced apartments are spacious with en-suites. |
| 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 | The care centre has two lounge areas where most activities take place. A dining room is spacious to accommodate residents in wheelchairs. There is a smaller dining room attached to the main lounge. There are several seating alcoves within the facility. All communal areas are accessible to residents. Wellness partners assist or transfer residents to communal areas for dining and activities as required.  |
| 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 | There are laundry and cleaning policies and procedures. Laundry services are done on site. There is a defined dirty to clean flow in the laundry. The laundry is equipped with two commercial washing machines in the dirty area. There are two dryers situated in the clean area/folding room. The laundry room is combined as a sluice/laundry. The room is not locked; however, all chemicals are dispensed automatically, and others are stored securely (sighted). Processes are in place to ensure that clean laundry (after drying) is placed in a covered clean trolley to transfer to residents’ rooms and linen cupboards situated around the facility. The laundry assistant interviewed was knowledgeable around infection control practise and management of infectious laundry. Material safety datasheets are available in the combined laundry. Personal protective equipment including gloves, aprons and eyewear are available for staff throughout the facility. The sluice is located in the laundry on the ground floor. There is a locked cleaner’s cupboard. The cleaner’s trolley is locked away in the cleaner’s cupboard when not in use. All chemicals on the cleaner’s trolley were labelled and in original containers and chemicals are stored in the lockable cupboard in the cleaning trolley when in use. The cleaner was observed using best practice including the use of colour coded cloths and mops. There is an internal audit around laundry services and environmental cleaning completed as part of the internal audit schedule. Staff have completed chemical safety training. |
| Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations. | FA | The disaster management policy (includes the pandemic plan) outlines the specific emergency response and evacuation requirements specific to Arvida Molly Ryan and document duties/responsibilities of staff and clear communication channels in the event of an emergency. The emergency management procedure guides staff to complete a safe and timely evacuation of the facility in the case of an emergency, and the business continuity plan document an action plan in case of failure of IT systems. An approved fire evacuation plan is in place. A fire evacuation drill was held with fire evacuation training conducted in October 2021 instead of a fire drill (due to Covid-19 lockdown measures). Outside contractors maintain the fire equipment. The maintenance person oversees contractor induction and management.There are emergency management plans in place to ensure health, civil defence and other emergencies are included. There are emergency folders with specific information held in the nurses’ station including requirements for each resident to safely evacuate. Emergency contact numbers are on display. Civil defence supplies are stored in a centrally accessible area near the kitchen. All supplies including food stores are checked monthly. In the event of a power outage there is a back-up generator and gas cooking available. There are adequate supplies in the event of a civil defence emergency including a 4200 litre water ceiling tanks supplemented with plenty of immediate 20-litre containers of drinkable water. Alternative sources for power and cooking are available. Emergency management is included in staff orientation and ongoing as part of the education plan. A minimum of one person trained in first aid is available at all times. There are call bells in the residents’ rooms and en-suites, communal toilets and lounge/dining room areas. Indicator lights are displayed above resident doors to alert them of who requires assistance. Residents were observed to have their call bells in close proximity. The building is secure after hours and staff complete security checks at night. A security company provides support through routine visits. The front entrance gate closes at set times. |
| 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 | Residents are provided with adequate natural light and safe ventilation. Resident rooms are heated with radiator heating which can be individually thermostat controlled. |
| 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 | Arvida Molly Ryan has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. A clinical manager is the designated infection control coordinator with support from the national quality manager. The clinical manager has a signed infection control job description. The clinical manager and staff is involved in the infection control meetings that is linked to clinical, staff and quality meetings. Internal audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The infection control programme has been reviewed annually.Resident education occurs during cares or opportunities at resident meetings.There are clear channels documented related to management of an outbreak management. Visitors are requested not to visit when unwell. |
| 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 | There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The infection control (IC) coordinator and IC team; two caregivers, kitchen, cleaning, and laundry representatives, have external support from the Arvida Group support office and the IC nurse specialist at the DHB. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available. Staff were observed practising good hand hygiene.The Covid-19 policies are implemented at all service levels and reflect the national response to Covid-19 and MOH requirements for aged residential care facilities.There are sufficient stock including isolation kits, masks and other PPE. Staff interviewed confirmed they adhere to cleaning practices for equipment use between residents, reusable items but also touch screens and computer equipment.  |
| 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 | There are Arvida Group infection control policies and procedures that are appropriate for the size and complexity of the service. The infection control manual outlines a range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. Policies include Covid-19 preparedness, guidelines specific to different alert levels and cleaning procedures include reusable eyewear and cleaning between equipment use.Policies have been reviewed and updated. Policies include information and a response framework on Covid-19 preparedness including cleaning and laundry practices. |
| Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred annually. Staff completed competencies for handwashing and the correct use of personal protective equipment (PPE). All staff complete infection control orientation and questionnaires on employment. Information is provided to residents that is appropriate to their needs and this is documented in clinical records and resident meetings (as applicable).The infection control policy states that the facility is committed to the ongoing education of staff and residents. All staff complete infection control education on the Altura system. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in their medical records.  |
| 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 | Infection surveillance is an integral part of the infection control programme and is described in the Arvida group infection control manual. Infection monitoring is the responsibility of the infection control coordinator. All infections are entered into the electronic database, which generates a monthly analysis of the data. Monthly infection data is collected for all infections based on signs, symptoms, and definition of infection. Infections are entered into the infection register on the electronic data base. Surveillance of all infections (including organisms) is entered onto a monthly infection summary. This data is monitored and analysed for trends monthly and annually. Infection control surveillance is discussed at facility meetings and meeting minutes are displayed for staff. Action plans are required for any infection rates of concern. Internal infection control audits are completed with corrective actions for areas of improvement. The service receives benchmarking feedback from Arvida Group support office.An organisational Covid-19 strategy and pandemic plan was available to staff on site with links to education and associated resources relating to hand hygiene, PPE, and donning/doffing procedures. Covid-19 education was also provided for all residents, including hand hygiene and use of PPE, these details being passed on to families via email, telephone and in writing. All staff and most residents have received the required Covid-19 vaccinations. All visitors, entertainers and contractors are required to be double vaccinated when visiting within the facility. Hand sanitisers were appropriately placed throughout the facility. Residents are offered the annual influenza vaccine. The Arvida infection control programme has been reviewed annually. There has been one respiratory outbreak in August 2021, was of short duration, contained, and sufficiently managed. Debrief meetings with staff (sighted) followed and included discussions from lessons learned.  |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | There are policies around restraints and enablers. There was one restraint used in the service (a lap belt). There were no enablers used in the service. Any use of enablers would be voluntary as per policy. Staff receive training around restraint minimisation that includes annual competency assessments. The restraint committee is facilitated by the restraint coordinator (clinical manager). Staff education on alternatives to restraint and management of challenging behaviour has been provided in 2021.  |
| Standard 2.2.1: Restraint approval and processesServices maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.  | FA | The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator (clinical manager) and for staff are documented and understood. The restraint coordinator interviewed, was able to describe their role in the use of restraint and in overseeing implementation of the care plan with a job description documented. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements. |
| Standard 2.2.2: AssessmentServices shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | One hospital level resident where restraint was in use (lap belt) was selected for review and the resident record contained a completed assessment. The completed assessment is comprehensive. The restraint coordinator is in partnership with the RNs, GP, resident, and their family/whānau, as part of the assessment process. Restraint assessments are used to underpin care planning around restraint and management of any safety concerns. Ongoing consultation with the resident and family/whānau was evident.  |
| Standard 2.2.3: Safe Restraint UseServices use restraint safely | FA | Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint. In this instance, the staff tried one-to-one staffing (not sustainable when other residents required support), and on one occasion the use of a bean bag (identified as an incident for an emergency use of restraint) with staff checking every five minutes when the resident was in the bean bag. An incident form was well documented for the use of the restraint that had not been consented for. Other interventions have included providing food and fluids, distraction and activities. The family and GP requested the use of a lap belt which is only used if the resident has hallucinations associated with the disease. Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident and hourly for this resident with the lap belt. |
| Standard 2.2.4: EvaluationServices evaluate all episodes of restraint. | FA | The service has documented evaluation of restraint every three months. In the file reviewed, evaluations had been completed with the resident, family/whānau, restraint coordinator and medical practitioner. Restraint practices are reviewed on a formal basis every month by the restraint coordinator at quality and RN meetings. Evaluation timeframes are determined by risk levels. The restraint evaluation is a thorough review.  |
| Standard 2.2.5: Restraint Monitoring and Quality ReviewServices demonstrate the monitoring and quality review of their use of restraint. | FA | The clinical manager is the restraint coordinator and reports to the quality team on a regular basis. The service has actively worked to promote a restraint free environment. The organisation also supports, and reviews restraint use across all its sites to minimise restraint.  |

# 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 | Data collected and collated are used to identify areas that require improvement. Clinical indicator data has individual reference ranges for acceptable organisational limits. The falls data (January 2020 - December 2020) showed significant increase in falls related injuries. A quality improvement projects implemented in January 2021 to reduce falls per 1000 bed night by 20% for all ARRC residents.  | Residents’ falls are monitored monthly, with strategies implemented to reduce the number of falls including: a). Highlighting residents at risk and implementing individualised interventions to include improving mobility through exercises (Thai Chi and walking train), GP assessment to assess for underlying causes and ensure optimisation of medication, referral for physiotherapy assessments and development of mobility plans, and include a multidisciplinary participation including the resident/whanau. b). Review of the resident’s environment including implementation of falls prevention equipment such as sensor mats, improving nutrition and hydration, including high protein smoothies to build muscle mass, performing intentional rounding checks, and providing staff education. Weekly call bell reports in the nurse’s station highlights call bell response time and create awareness and discussions for improvement. Rosters reviewed to ensure sufficient staff numbers for oversight. Wellness partners and RNs interviewed were knowledgeable regarding preventing falls and those residents who were at risk. The falls prevention programme has been reviewed monthly and is regularly discussed at staff meetings. A review of the data evidenced a decrease of falls incidents per 1000 bed nights by 23% from Q1- Q4 in 2021. Excluding a frequent faller (spike in data), the falls rate was under the Arvida target of 11/1000 bed nights and external benchmark of 10/1000 bed nights. Comprehensive multidisciplinary input was evident in one resident (frequent falls) file. The Arvida dementia wellbeing coach provided further strategies to prevent falls.  |

End of the report.