

Mossbrae Lifecare Limited - Mossbrae Lifecare

Introduction

This report records the results of a Provisional Audit of a provider of aged residential care services against the Ngā Paerewa Health and Disability Services Standard (NZS8134:2021).

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 0.4 of the Ngā Paerewa Health and Disability Services Standard (NZS8134:2021).

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

The specifics of this audit included:

Legal entity:	Mossbrae Lifecare Limited
Premises audited:	Mossbrae Lifecare
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 14 July 2022 End date: 15 July 2022
Proposed changes to current services (if any):	Sale and purchase
Total beds occupied across all premises included in the audit on the first day of the audit:	54

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 sections contained within the Ngā Paerewa Health and Disability Services Standard:

- ō tatou motika | our rights
- hunga mahi me te hanganga | workforce and structure
- ngā huarahi ki te oranga | pathways to wellbeing
- te aro ki te tangata me te taiao haumarū | person-centred and safe environment
- te kaupare pokenga me te kaitiakitanga patu huakita | infection prevention and antimicrobial stewardship
- here taratahi | restraint and seclusion.

General overview of the audit

Mossbrae Lifecare provides rest home and hospital level care and non-aged residential care for people with long term conditions for up to sixty-four residents. All beds are dual purpose. The service is operated by Mossbrae Lifecare Ltd and managed by a general manager who has managed the service since March 2020. There are two care managers. Residents and families interviewed spoke positively about the care provided.

This provisional audit was conducted against the Health and Disability Services Standards (2021) and the service's contract with the DHB and the MoH. The audit process included review of documents, review of residents' and staff files, observations and interviews with residents, family members, managers, staff, contracted allied health providers, a general practitioner and the prospective purchaser.

Improvements are required to address staffing levels, employment records, orientation, performance appraisals, interRAI assessments, medication management and call bells. Three of these improvement requests also relate to shortfalls at the 2021 certification audit.

Ō tatou motika | Our rights

Mossbrae Lifecare works collaboratively to support and encourage a Māori world view of health in its service delivery. Māori are provided with equitable and effective services based on Te Tiriti o Waitangi and the principles of mana motuhake.

Residents and families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumer Rights' (the Code) and these are respected. The service works collaboratively to support and encourage a Māori world view of health in service delivery. Māori are provided with equitable and effective services based on the Te Tiriti o Waitangi.

Services provided support personal privacy, independence, individuality, and dignity. Staff interacted with residents in a respectful manner. There was no evidence of abuse, neglect, or discrimination.

Open communication between staff, residents, and families is promoted and was confirmed to be effective. Whānau and legal representatives are involved in decision-making that complies with the law. Advance directives are followed wherever possible. The service works with other community health agencies.

Complaints are addressed and resolved promptly and effectively in collaboration with the parties involved.

Hunga mahi me te hanganga | Workforce and structure

The family owned and operated governing body assumes accountability for delivering a service that meets the needs of residents. This service is 'on a journey' to ensure it honours Te Tiriti o Waitangi and reduce barriers to improved outcomes for Māori and people with disabilities using the facility.

Strategic planning ensures the purpose, values, direction, scope and goals for the organisation are defined. The quality and risk management systems are focused on improving service and care delivery. Residents and families provide regular feedback and staff are involved in quality activities. Collection and analysis of quality improvement data and performance monitoring is used to identify trends and leads to improvements. Actual and potential risks are identified and mitigated, including health and safety risks.

Adverse events are documented in an electronic system, with corrective actions planned and implemented where improvement is required. The service complies with statutory and regulatory reporting obligations.

Staffing levels and skill mix have been impacted by the pandemic and nationwide staffing shortages, but every effort has been made to meet the cultural and clinical needs of residents throughout. Staff are appointed, orientated, and managed using current good human resource practices. A systematic approach to identify and deliver ongoing learning supports safe, equitable service delivery.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people.

Ngā huarahi ki te oranga | Pathways to wellbeing

Residents are assessed before entry to the service to confirm their level of care. The nursing team are responsible for the assessment, development, and evaluation of care plans. Care plans are individualised and based on the residents' assessed needs. Interventions are appropriate and evaluated.

There are planned activities developed to address the needs and interests of the residents as individuals and in group settings. Activity plans are completed in consultation with family/whānau, residents, and staff. Residents and family/whānau expressed satisfaction with the activities programme in place.

There is a medicine management system. The organisation uses an electronic system in e-prescribing, dispensing, and administration of medications. The general practitioner (GP) is responsible for all medication reviews. Staff involved in medication administration are assessed as competent to do so.

The food service caters for residents' specific dietary likes and dislikes. Residents' nutritional requirements are met. Nutritional snacks are available for residents 24 hours a day.

Residents are referred or transferred to other health services as required.

Te aro ki te tangata me te taiao haumaruru | Person-centred and safe environment

The facility meets the needs of residents and was clean and well maintained. There was a current building warrant of fitness issued by Dunedin City Council. Electrical equipment has been tested as required. External areas are accessible, safe and provide shade and seating, and meet the access needs of people with disabilities.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire training. Staff, residents and whānau understood emergency and security arrangements. A call bell system is in place. Security is maintained.

Te kaupare pokenga me te kaitiakitanga patu huakita | Infection prevention and antimicrobial stewardship

The governing body ensures the safety of resident and staff through a planned infection prevention and antimicrobial stewardship programme that is appropriate to the size and complexity of the service. It is adequately resourced.

The infection control coordinator is involved in procurement processes, and any facility changes, and processes related to decontamination of any reusable devices.

Staff demonstrated good principles and practice around infection control. Staff, residents, and whānau were familiar with the pandemic/infectious diseases response plan.

Aged care-specific infection surveillance is undertaken with follow-up action taken as required.

The environment supports the prevention and transmission of infections. Waste and hazardous substances are well managed. There are safe and effective laundry services.

Here taratahi | Restraint and seclusion

The service has very limited use of restraint. A restraint register records use of a bedrail. Staff have previously received training in use of restraint.

Summary of attainment

The following table summarises the number of subsections 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)
Subsection	0	23	0	1	4	0	0
Criteria	0	139	0	3	5	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)
Subsection	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Ngā Paerewa Health and Disability Services Standard

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

There may be subsections in this audit report with an attainment rating of ‘not applicable’ which relate to new requirements in Ngā Paerewa that the provider is working towards. The provider will be expected to meet these requirements at their next audit.

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

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

Subsection with desired outcome	Attainment Rating	Audit Evidence
<p>Subsection 1.1: Pae ora healthy futures</p> <p>Te Tiriti: Māori flourish and thrive in an environment that enables good health and wellbeing.</p> <p>As service providers: We work collaboratively to embrace, support, and encourage a Māori worldview of health and provide high-quality, equitable, and effective services for Māori framed by Te Tiriti o Waitangi.</p>	FA	<p>There are no Māori residents in the facility. Guidance for staff is available to respect the right to Māori to self-determination, and provision of a culturally safe service.</p> <p>Documented policies for cultural safety and guidance for staff on Māori health care delivery is available.</p> <p>The service has commenced collection of data in relation to staff ethnicity and this work is almost complete. Although work in progress, this is expected to support recruitment decisions going forward.</p> <p>ARC facilities are beginning collaboration through their collective group to develop high quality, equitable and effective services for Māori.</p>
<p>Subsection 1.2: Ola manuia of Pacific peoples in Aotearoa</p> <p>The people: Pacific peoples in Aotearoa are entitled to live and</p>	Not applicable	<p>Currently, Mossbrae Lifecare has no Pacific peoples in its service, and no specific guidance on supporting Pacific peoples. There were 2.8% of the population who identified as Pasifika at the last census in</p>

<p>enjoy good health and wellbeing.</p> <p>Te Tiriti: Pacific peoples acknowledge the mana whenua of Aotearoa as tuakana and commit to supporting them to achieve tino rangatiratanga.</p> <p>As service providers: We provide comprehensive and equitable health and disability services underpinned by Pacific worldviews and developed in collaboration with Pacific peoples for improved health outcomes.</p>		<p>the Otago region. It was observed that the service has developed and maintained its services in a manner that is equitable and respectful of all peoples' rights and upholds their cultural and individual values and beliefs. Cultural competency training is provided although no specific arrangements reflect the needs of Pacific people. There is presently no reference to the needs of Pacific people in the cultural health plan.</p> <p>The service captures ethnicity data as part of its referral processes. Pasifika numbers in the region remain relatively small (2.8% of the population), however utilising this information will assist the organisation to develop suitable models of care for Pacific peoples as well as identify the training needs of staff. The service has not yet determined the best way to engage meaningfully with consumers or develop a workforce strategy for Pacific peoples. This subsection of the standard requires development.</p>
<p>Subsection 1.3: My rights during service delivery</p> <p>The People: My rights have meaningful effect through the actions and behaviours of others.</p> <p>Te Tiriti: Service providers recognise Māori mana motuhake (self-determination).</p> <p>As service providers: We provide services and support to people in a way that upholds their rights and complies with legal requirements.</p>	FA	<p>All staff interviewed understood the requirements of the Code of Health and Disability Services Consumers' Rights (the Code) and were observed supporting residents following their wishes. Family/whānau and residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) and confirmed they were provided with opportunities to discuss and clarify their rights. The Code is available in Māori and English languages.</p> <p>There were no residents who identified as Māori. The care manager (CM) reported that the service recognises Māori mana motuhake (self-determination) of residents, family/whanau, or their representatives in its updated cultural safety policy. The assessment process includes the resident's wishes and support needs.</p> <p>The prospective owner demonstrated a good understanding of the consumers' rights legislation and they own a number of aged care facilities across the country.</p>
<p>Subsection 1.4: I am treated with respect</p> <p>The People: I can be who I am when I am treated with dignity and</p>	FA	<p>The service supports residents in a way that is inclusive and respects their identity and experiences. Residents and whanau, including people with disabilities, confirmed that they receive services in a</p>

<p>respect.</p> <p>Te Tiriti: Service providers commit to Māori mana motuhake.</p> <p>As service providers: We provide services and support to people in a way that is inclusive and respects their identity and their experiences.</p>		<p>manner that has regard for their dignity, gender, privacy, sexual orientation, spirituality, choices, and characteristics. Records sampled confirmed that each resident's individual cultural, religious, and social needs, values, and beliefs had been identified, documented, and incorporated into their care plan.</p> <p>The CM reported that residents are supported to maintain their independence by staff through daily activities. Residents were able to move freely within and outside the facility.</p> <p>There is a documented privacy policy that references current legislation requirements. All residents have an individual room. Staff were observed to maintain privacy throughout the audit, including respecting residents' personal areas and by knocking on the doors before entering.</p> <p>All staff are required to complete training on Te Tiriti o Waitangi and culturally inclusive care as part of orientation and annually however some had not yet completed this (refer 2.4.4). Te reo Māori and tikanga Māori practices are promoted within the service through activities undertaken, such as policy reviews and translation of English words to Māori in some cases.</p>
<p>Subsection 1.5: I am protected from abuse</p> <p>The People: I feel safe and protected from abuse.</p> <p>Te Tiriti: Service providers provide culturally and clinically safe services for Māori, so they feel safe and are protected from abuse.</p> <p>As service providers: We ensure the people using our services are safe and protected from abuse.</p>	<p>FA</p>	<p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. The induction process for staff includes education related to professional boundaries, expected behaviours, and the code of conduct. A code of conduct statement is included in the staff employment agreement. Professional boundaries are maintained. The CM reported that staff are guided by the code of conduct to ensure the environment is safe and free from any form of institutional and systemic racism. Family members stated that residents were free from any type of discrimination, harassment, physical or sexual abuse or neglect and were safe. Policies and procedures such as the harassment, discrimination, and bullying policy are in place. The policy applies to all staff, contractors, visitors, and residents. The CM stated that there have been no reported alleged episodes of abuse, neglect, or discrimination towards residents. There were no documented incidents of abuse or neglect in</p>

		<p>the records sampled. There are systems and processes in place to ensure residents' finances and personal property such as hearing aids, eyeglasses, and other aids, are in good working order, maintained, and kept securely. Documentation to support this was sighted.</p> <p>The Māori Health Care Plan in place identifies strengths-based, person-centred care and general healthy wellbeing outcomes for Māori residents.</p>
<p>Subsection 1.6: Effective communication occurs</p> <p>The people: I feel listened to and that what I say is valued, and I feel that all information exchanged contributes to enhancing my wellbeing.</p> <p>Te Tiriti: Services are easy to access and navigate and give clear and relevant health messages to Māori.</p> <p>As service providers: We listen and respect the voices of the people who use our services and effectively communicate with them about their choices.</p>	<p>FA</p>	<p>Residents and whānau reported that communication was open and effective, and they felt listened too. EPOA/whānau/family stated they were kept well informed about any changes to their relative's health status and 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. Staff understood the principles of open disclosure, which are supported by policies and procedures.</p> <p>Personal, health, and medical information from other allied health care providers is collected to facilitate the effective care of residents. Each resident had a family or next of kin contact section in their file.</p> <p>There were no residents who required the services of an interpreter; however, the staff knew how to access interpreter services if required. Staff can provide interpretation as and when needed and use family members as appropriate.</p> <p>There were no residents under the palliative care contract at the time of the audit. The CM reported that anticipatory discussions and the implementation of holistic, resident centred clinical care is conducted on an ongoing basis and residents, EPOA/whānau/family are updated regularly and as when required. This was further evidenced in the palliative care policy reviewed, stating that the nursing team will be proactive in ascertaining a resident's preferences and choices in regard to interventions and plan of care. The CM also affirmed that all residents in isolation will be provided with a stimulating environment</p>

		<p>that allows constant communication with EPOA/whānau /family.</p> <p>The CM reported that verbal and non-verbal communication cards and regular use of hearing aids by residents when required is encouraged.</p>
<p>Subsection 1.7: I am informed and able to make choices</p> <p>The people: I know I will be asked for my views. My choices will be respected when making decisions about my wellbeing. If my choices cannot be upheld, I will be provided with information that supports me to understand why.</p> <p>Te Tiriti: High-quality services are provided that are easy to access and navigate. Providers give clear and relevant messages so that individuals and whānau can effectively manage their own health, keep well, and live well.</p> <p>As service providers: We provide people using our services or their legal representatives with the information necessary to make informed decisions in accordance with their rights and their ability to exercise independence, choice, and control.</p>	FA	<p>The staff interviewed understood the principles and practice of informed consent. Informed consent policies provided relevant guidance to staff. Residents' files sampled verified that informed consent for the provision of care had been gained appropriately using the organisation's standard consent form. These are signed by the enduring power of attorney (EPOA) and residents. The GP makes a clinically based decision on resuscitation authorisation in consultation with residents and family/whanau. The CM reported that advance directives are explained and encouraged.</p> <p>Staff were observed to gain consent for day-to-day care, and they reported that they always check first if a consent form is signed before undertaking any of the actions that need consent. Interviews with relatives confirmed the service actively involves them in decisions that affect their family members' lives. All consent forms are signed and kept in the residents' files. Residents reported that they felt safe, protected and listened to and were happy with care and consent processes.</p> <p>There were no Māori residents at the time of the audit, the CM reported that tikanga best practice guidelines in relation to consent will be observed according to policy requirements.</p>
<p>Subsection 1.8: I have the right to complain</p> <p>The people: I feel it is easy to make a complaint. When I complain I am taken seriously and receive a timely response.</p> <p>Te Tiriti: Māori and whānau are at the centre of the health and disability system, as active partners in improving the system and their care and support.</p>	FA	<p>A fair, transparent, and equitable system in accordance with the organisation's policies is in place to receive and resolve complaints. Where needed, this leads to service improvements. This meets the requirements of the Code. Formal complaints about the health services can be received either verbally or in writing. A register is maintained. Complaints are addressed and investigated by the general manager. Residents and whānau understood their right to make a complaint and knew how to do so. Documentation sighted showed that complainants had been informed of findings following</p>

<p>As service providers: We have a fair, transparent, and equitable system in place to easily receive and resolve or escalate complaints in a manner that leads to quality improvement.</p>		<p>investigation, including apologies where necessary.</p> <p>There have been four new complaints in the past year and two others passed on by the DHB. These have been completed. An HDC complaint arising in July 2020 has been closed with recommendations and changes made. As requested, these have been followed up at this audit and commented on in the report where issues remain (refer also 4.2.5). The service cannot yet demonstrate that the complaints process works equitably for Māori.</p>
<p>Subsection 2.1: Governance</p> <p>The people: I trust the people governing the service to have the knowledge, integrity, and ability to empower the communities they serve.</p> <p>Te Tiriti: Honouring Te Tiriti, Māori participate in governance in partnership, experiencing meaningful inclusion on all governance bodies and having substantive input into organisational operational policies.</p> <p>As service providers: Our governance body is accountable for delivering a high quality service that is responsive, inclusive, and sensitive to the cultural diversity of communities we serve.</p>	<p>FA</p>	<p>The governing body is a family-owned business which operates two other facilities. It assumes accountability for delivering a high-quality service for up to 64 residents. The service holds contracts with Te Whatu Ora Southern (DHB) for aged residential care, respite care, complex medical conditions, and palliative care. Fifty-four residents were receiving services under these contracts, of whom six residents were rest home level care, two respite care, and forty-six hospital level care including one resident with exceptional circumstances. All rooms are dual purpose, including premium rooms.</p> <p>There is a defined governance and leadership structure, including for clinical governance, that is appropriate to the size and complexity of the organisation. This includes a quality plan, a quality and risk and internal audit programme, which incorporates the purpose, values, direction, scope and goals for the organisation. The general manager (GM) has been in the role since March 2020 and is suitably qualified and experienced to manage the service. The GM has strong networks within the DHB and wider sector, a good understanding of regulatory and reporting requirements and maintains currency within the field.</p> <p>A number of operational committees meet at varying frequency to oversee quality activities, health and safety, infection control, clinical issues and to plan improvements. Meetings held are minuted, including those involving residents. A sample of reports prepared by the general manager for the owners each month showed adequate and appropriate information and performance indicators are reported. There is regular interaction with the regional manager, who also</p>

		<p>supports the operational processes to ensure safe services.</p> <p>It was evident that further development is required to formalise and fully engage with Māori, Pacific peoples, those with disabilities and other diverse groups to ensure equity and positive outcomes for all people using the service. It is anticipated that this will be supported through the local ARC collective, working together at regional level.</p> <p>The prospective provider has an established governance (Board of Directors) and organisational structure (Managing Director, a clinical operations manager and a chief financial officer, all of whom are Auckland based. New Zealand Aged Care owns and operates other aged care facilities in the North Island. Pre purchase due diligence is progressing, and the funder advised. Policies and procedures will remain intact and reviewed when necessary (and not all at the same time). The management structure will remain the same i.e., a care manager and general manager. The current regional manager is likely to remain during the roll over (three months) and care staff are being offered positions with the new company.</p>
<p>Subsection 2.2: Quality and risk</p> <p>The people: I trust there are systems in place that keep me safe, are responsive, and are focused on improving my experience and outcomes of care.</p> <p>Te Tiriti: Service providers allocate appropriate resources to specifically address continuous quality improvement with a focus on achieving Māori health equity.</p> <p>As service providers: We have effective and organisation-wide governance systems in place relating to continuous quality improvement that take a risk-based approach, and these systems meet the needs of people using the services and our health care and support workers.</p>	<p>FA</p>	<p>The organisation has a planned quality and risk management system that reflects the principles of continuous quality improvement. An annual quality plan is in place for 2022. The programme includes management of incidents and complaints, internal audit activities, resident and staff satisfaction surveys, monitoring of outcomes, policies and procedures, clinical incidents including infections and resident falls. Improvement activities are focussed on the 'plan-do-check-act' cycle. Residents, whānau and staff contribute to quality improvement occurs through the meeting and feedback framework. Progress against quality outcomes is evaluated.</p> <p>The resident satisfaction survey was completed in June 2022 and a meal satisfaction survey was undertaken the same month. Results from the meal survey indicated that improvement was needed in relation to the temperatures and variety of served meals. Actions to address this effectively are continuing with the contracted meal provider.</p>

	<p>Results from events are analysed, extrapolated and graphed as appropriate. Internal audits are undertaken according to an annual schedule. Audit completions have been impacted by the pandemic and staffing disruption, but efforts have been made to maintain the audit schedule. A summary is prepared as part of an annual review. Audits include a care plan audit, code of rights, IPC competencies, medication and environmental safety (all undertaken in June 2022 and requiring follow up actions and/or training). Call bell audits relied on anecdotal reporting. This audit has not been maintained (see CAR 4.2.5).</p> <p>Policies reviewed covered all necessary aspects of the service and contractual requirements and those sighted were current, although will require referencing to the revised HDSS standard.</p> <p>The GM described the processes for the identification, documentation, monitoring, review and reporting of risks, including health and safety risks, and development of mitigation strategies. Changes in risk are reported.</p> <p>Staff document adverse and near miss events in an electronic system in line with the National Adverse Event Reporting policy. A sample of recorded incidents reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Relevant corrective actions are developed and implemented to address any shortfalls. Root cause analysis is undertaken where an in-depth investigation is required. Outcomes are reviewed and include graphing of trends which are included in the GM report.</p> <p>The GM understood and has complied with essential notification reporting requirements. Records of Section 31 notifications were sighted, primarily related to staffing shortfalls. Notification of outbreaks have occurred (Covid-19 and suspected norovirus) as required. A further notification has been made to a professional body. There have been no police, coroner or workplace notifications.</p> <p>Meeting frequency for staff and residents has also been disrupted</p>
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		<p>over the past year. While these meetings have occurred less frequently than planned, notes are available and accessible as a record of activity.</p> <p>Work is still required to identify and address any cultural and equity barriers for people using the service and improve health equity through analysis of current organisational practices.</p> <p>The new provider interview confirms that, initially, the facility will retain its own quality systems and the purchaser will work with the facility to ensure all areas are met. The prospective provider has commenced updates of policies and procedures to reflect the requirements of Ngā Paerewa in its existing facilities. These will be shared as appropriate with the Dunedin services over time. There are no legislative compliance issues known to the new provider as part of their due diligence process.</p>
<p>Subsection 2.3: Service management</p> <p>The people: Skilled, caring health care and support workers listen to me, provide personalised care, and treat me as a whole person.</p> <p>Te Tiriti: The delivery of high-quality health care that is culturally responsive to the needs and aspirations of Māori is achieved through the use of health equity and quality improvement tools.</p> <p>As service providers: We ensure our day-to-day operation is managed to deliver effective person-centred and whānau-centred services.</p>	<p>PA Low</p>	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide culturally and clinically safe care, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. At times, there are gaps in the roster for both care staff and registered and enrolled nurses, which are routinely reported using a section 31 notification form. This is related, in part, to the nationwide staffing shortages across the sector and the effect of ongoing staff illness during the pandemic. The service has a strategy to recruit overseas nurses and, once settled in a caregiver role, to support them to complete the CAP nursing programme. These staff are bonded to the facility for two years.</p> <p>Not all registered nursing staff hold a current first aid certificate to ensure at least one staff member on duty holds this qualification. Updates are continuing. There is routinely two registered and/or enrolled staff rostered across the facility, with some self-rostering for this group. Care staff have a rotating six-week roster.</p>

		<p>Continuing education is planned on an annual basis, including mandatory training requirements. Related competencies are assessed and support equitable service delivery. Recently this is being aligned with annual performance appraisals and this is progressing well. A registered nurse is employed as a care manager, but also has responsibility for developing and implementing mandatory training plans using experiential learning where possible. A suite of resources has been made available for both sites. There is presently limited use of online learning platforms although this is developing. Presently, a framework for cultural safety training is almost complete. Staff have received training on the use of Te Ara Whakapiri, with resources available. The local hospice nurse specialist has offered training in grief and loss and consideration is being given to incorporating the fundamentals of palliative care for interested staff. Records of training are maintained.</p> <p>Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. There is an increasing focus on level four qualifications to strengthen workforce capability. Two staff are enrolled in the level four diversional therapy programme. Registered nurses can access a range of post graduate training through the DHB and university although none are currently undertaking post graduate programmes. The service also offers placements for those on the enrolled nurse training pathway.</p> <p>Family/whānau commented that visiting has been difficult due to the Covid-19 restrictions and that they have observed staff are under pressure at times. See also comments 4.2 in relation to call bell responses times. It could not be determined whether call bell response times are linked to staffing shortages over recent months.</p> <p>Further development is required to meet criterion related to use of ethnicity data, service participation and health equity expertise. Management state they will support staff who need assistance with maintaining their wellbeing, although there are no formal systems in place such as an employee assistance programme. Staff spoken to reported that the past two years has been a stressful period. Bullying</p>
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		<p>and harassment training has been requested.</p> <p>The prospective provider has clear guidance and expectations of staffing and skill mix. Staff changing shifts must have this agreed in writing to ensure there is not an imbalance of junior staff. The goal is to ensure that staffing is adequate, professional and suitably trained. The national shortage of registered nurses is being addressed through strategies such as financial incentives paid to referrers of suitable new staff who stay at least three months in the service. International registered nurses are supported to undertake a CAP (competence assessment programme) course after a period of employment. The prospective provider understands the contractual requirements for safe staffing.</p>
<p>Subsection 2.4: Health care and support workers</p> <p>The people: People providing my support have knowledge, skills, values, and attitudes that align with my needs. A diverse mix of people in adequate numbers meet my needs.</p> <p>Te Tiriti: Service providers actively recruit and retain a Māori health workforce and invest in building and maintaining their capacity and capability to deliver health care that meets the needs of Māori.</p> <p>As service providers: We have sufficient health care and support workers who are skilled and qualified to provide clinically and culturally safe, respectful, quality care and services.</p>	<p>PA Moderate</p>	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. All employees have a job description for the role they undertake. Standards of conduct apply to all employees. Professional qualifications are validated at the time of appointment. Information is filed in hard copy or records of education summarised in spreadsheets. Employment records include interview notes, referee checks and police vetting consents which are kept securely. Ethnicity data is starting to be collected.</p> <p>A sample of nine staff records reviewed confirmed the organisation's policies in relation to recruitment are followed. Police vetting is undertaken although a sample of four staff employed prior to 2020 have no records on file. There is no implemented process for re-vetting of staff. Efforts have been made to complete updates for staff requiring first aid certificates, however this remains work in progress (2.4.1).</p> <p>Staff performance is planned for on an annual review, although currency has not been maintained in recent times (2.4.5). Ethnicity data is now being sought from all staff. This is recorded in the payroll system and used in line with health information standards.</p> <p>A structured two-hour orientation programme is undertaken on</p>

		<p>commencement and buddy sessions for another three to four shifts before working independently. The orientation programme includes completion of specified competencies which are signed off when completed and repeated annually. A formal group session of orientation is also implemented; however, this has not been completed for staff employed in the last several months (2.4.4). A catch-up session is booked for these staff in late July 2022.</p> <p>The GM meets with staff to discuss and learn from any adverse events and debriefs staff where necessary.</p>
<p>Subsection 2.5: Information</p> <p>The people: Service providers manage my information sensitively and in accordance with my wishes.</p> <p>Te Tiriti: Service providers collect, store, and use quality ethnicity data in order to achieve Māori health equity.</p> <p>As service provider: We ensure the collection, storage, and use of personal and health information of people using our services is accurate, sufficient, secure, accessible, and confidential.</p>	FA	<p>All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current, integrated and legible and met current documentation standards.</p> <p>Residents' files are held securely for the required period before being destroyed. No personal or private resident information was on public display during the audit. NHI records are maintained.</p> <p>Resident files and the information associated with residents and staff are retained in hard copy. All electronic information are backed-up and password protected. Records are uniquely identifiable, legible, and timely including staff signatures, designation, and dates.</p> <p>Mossbrae Lifecare is not responsible for National Health Index registration of people receiving services.</p>
<p>Subsection 3.1: Entry and declining entry</p> <p>The people: Service providers clearly communicate access, timeframes, and costs of accessing services, so that I can choose the most appropriate service provider to meet my needs.</p> <p>Te Tiriti: Service providers work proactively to eliminate inequities between Māori and non-Māori by ensuring fair access to quality care.</p>	FA	<p>The admission policy for the management of inquiries and entry to Mossbrae Lifecare is in place. The admission pack contains all the information about entry to the service. Assessments and entry screening processes are documented and communicated to the family/whānau of choice, where appropriate, local communities, and referral agencies. Completed Needs Assessment and Service Coordination (NASC) service authorisation forms for residents requiring, hospital, rest home, young people with disabilities (YPD), and respite, level of care were in place.</p>

<p>As service providers: When people enter our service, we adopt a person-centred and whānau-centred approach to their care. We focus on their needs and goals and encourage input from whānau. Where we are unable to meet these needs, adequate information about the reasons for this decision is documented and communicated to the person and whānau.</p>		<p>Records reviewed confirmed that admission requirements are conducted within the required time frames and are signed on entry. The CM reported that the rights and identity of the residents are protected by ensuring residents' information is kept confidential in locked cupboards. EPOA/family/whānau were updated where there was a delay to entry to service; this was observed on the days of the audit and in inquiry records sampled. Residents and EPOA/family/whānau interviewed confirmed that they were consulted and received ongoing and sufficient information regarding the services provided.</p> <p>The CM reported that all potential residents who are declined entry are recorded. When an entry is declined relatives are informed of the reason for this and made aware of other options or alternative services available. The consumer/family is referred to the referral agency to ensure the person will be admitted to the appropriate service provider.</p> <p>There were no residents who identified as Māori at the time of the audit.</p> <p>The service is actively working to ensure routine analysis to show entry and decline rates including specific data for entry and decline rates for Māori is implemented.</p> <p>The service is actively working towards partnering with local Māori communities, health practitioners, traditional Māori healers, and organisations to support Māori individuals and whānau.</p>
<p>Subsection 3.2: My pathway to wellbeing</p> <p>The people: I work together with my service providers so they know what matters to me, and we can decide what best supports my wellbeing.</p> <p>Te Tiriti: Service providers work in partnership with Māori and whānau, and support their aspirations, mana motuhake, and</p>	<p>PA Moderate</p>	<p>The residents' files sampled identified that initial assessments and initial care plans were resident centred, and these were completed on admission. The service uses assessment tools that included consideration of residents' lived experiences, cultural needs, values, and beliefs. Residents' care is undertaken by appropriately trained and skilled staff that include the GM, CMs, nursing team and care staff. Cultural assessments were completed by the nursing team who have completed appropriate cultural training. Long-term care plans were also developed with detailed interventions to address identified</p>

<p>whānau rangatiratanga.</p> <p>As service providers: We work in partnership with people and whānau to support wellbeing.</p>		<p>problems.</p> <p>Where progress was different from expected, the service, in collaboration with the resident or family/whānau responded by initiating changes to the care plan. The long-term care plans sampled reflected identified residents' strengths, goals, and aspirations aligned with their values and beliefs documented. The evaluations included the residents' degree of progress towards their agreed goals and aspirations as well as whānau goals and aspirations. Documented detailed strategies to maintain and promote the residents' independent well-being were sighted.</p> <p>All residents reviewed had assessments completed including behaviour, fall risk, nutritional requirements, continence, skin, cultural, and pressure injury assessments. The GPs visits the service once a week and is available on call when required. Medical input was sought within an appropriate timeframe, medical orders were followed, and care was person-centred. This was confirmed in the files reviewed and interview conducted with the GP. Residents' medical admission and reviews were completed. Residents' files sampled identified service integration with other members of the health team. Multidisciplinary team (MDT) meetings were completed annually.</p> <p>The CM reported that sufficient and appropriate information is shared between the staff at each handover. Interviewed staff restated that they are updated daily regarding each resident's condition. Progress notes were completed on every shift and more often if there were any changes in a resident's condition. A multidisciplinary approach is adopted to promote continuity in service delivery, and this includes the GP, CMs, nursing team, care staff, physiotherapist (PT) when required, podiatrist, and other members of the allied health team, residents, and family/whānau.</p> <p>Short-term care plans were developed for short-term problems or in the event of any significant change with appropriate interventions to guide staff. The plans were reviewed weekly or earlier if clinically indicated by the degree of risk noted during the assessment process. These were added to the long-term care plan if the condition did not</p>
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	<p>resolve in three weeks. Any change in condition is reported to the nursing team as evidenced in the records sampled. Interviews verified residents and family/whānau are included and informed of all changes. A range of equipment and resources were available, suited to the levels of care provided and the residents' needs. The family/whānau and residents interviewed confirmed their involvement in the evaluation of progress and any resulting changes. Each wound had individual wound assessment and management plans completed.</p> <p>The CM reported that any resident on palliative care or last days of life, will be assessed by the GP, nursing team and anticipatory conversations on impending death completed with residents and family/whānau where required. The same was reiterated by the GP in interview conducted. The CM further reported that the service was being supported by the local hospice team in the training of staff in palliative care and any advice that may be required. Residents in isolation are provided with a stimulating environment that promote effective communication with between affected residents and family/whānau.</p> <p>The Māori Health care plan in place reflects the partnership and support of residents, whanau, and the extended whānau as applicable to support wellbeing. Tikanga principles are included within the Māori Health Care Plan. Any barriers that prevent tangata whaikaha and whānau from independently accessing information or services are identified and strategies to manage these documented. This includes residents with a disability. The staff confirmed they understood the process to support residents and whanau.</p> <p>There were 31 overdue interRAI re-assessments covered by the waiver period and nine (9) overdue new interRAI assessments which needed to be completed. Outcome scores from interRAI assessments such as pain, falls, nutrition and behavioural issues were not being identified on long-term care plans. The previous area requiring improvement relating to developing required detailed interventions remains open (mapped to NZS 8134:2008, Criterion 1.3.5.2). Residents' dietary profiles were not consistently reviewed every six-</p>
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		months and dated on completion.
<p>Subsection 3.3: Individualised activities</p> <p>The people: I participate in what matters to me in a way that I like.</p> <p>Te Tiriti: Service providers support Māori community initiatives and activities that promote whanaungatanga.</p> <p>As service providers: We support the people using our services to maintain and develop their interests and participate in meaningful community and social activities, planned and unplanned, which are suitable for their age and stage and are satisfying to them.</p>	FA	<p>Planned activities are appropriate to the residents' needs and abilities. Activities are conducted by two activities coordinators. The programme runs from Monday to Friday with weekends reserved for church services and EPOA/whānau/family visits. The activities are based on assessments and reflected the residents' social, cultural, spiritual, physical, and cognitive needs/abilities, past hobbies, interests, and enjoyments. However, some interRAI assessment outcome scores were not identified on long term care plans (refer 3.2.5). Residents' birthdays are celebrated. A resident profile detailing their life history is completed for each resident within two weeks of admission in consultation with the family and resident.</p> <p>The activity programme is formulated by the activities coordinators in consultation with the GM, CM, regional director, EPOAs, residents, and activities care staff. The activities are varied and appropriate for people assessed as requiring rest-home, hospital, YPD and respite level of care. Residents assessed as requiring YPD care involved in activities of their choice.</p> <p>Activity progress notes and activity attendance checklists were completed daily. The residents were observed participating in a variety of activities on the audit days that were appropriate to their group settings. The planned activities and community connections were suitable for the residents. The service promotes access to EPOA/whānau/family and friends. Residents' activities and care plans were evaluated every six months or when there was any significant change. Van trips are conducted once a week except under Covid-19 national restrictions.</p> <p>In an interview conducted the activities staff reported that there were no residents who identify as Māori but opportunities for Māori and whānau to participate in te ao Māori would be facilitated through community engagements with community traditional leaders, and by celebrating religious and cultural festivals.</p> <p>EPOA/whānau/family and residents reported overall satisfaction with</p>

		the level and variety of activities provided.
<p>Subsection 3.4: My medication</p> <p>The people: I receive my medication and blood products in a safe and timely manner.</p> <p>Te Tiriti: Service providers shall support and advocate for Māori to access appropriate medication and blood products.</p> <p>As service providers: We ensure people receive their medication and blood products in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	PA Moderate	<p>The medication management policy was current and in line with the Medicines Care Guide for Residential Aged Care. Indications for use are noted for pro re nata (PRN) medications, including over-the-counter medications, and supplements. Allergies are indicated on all medicine charts, and all photos uploaded were current. Eye drops were dated on opening.</p> <p>Medication reconciliation is conducted by the nursing team when a resident is transferred back to the service from the hospital or any external appointments. The nursing team checked medicines against the prescription, and these were updated in the electronic medication management system. The registered nurse and caregiver were observed administering medications safely and correctly in both wings. Medications were stored safely and securely in the trolley, locked treatment room, and cupboards.</p> <p>The medication policy clearly outlines that residents', including Māori residents and their whānau, are supported to understand their medications. There was one resident self-administering medicines and this person was assessed as competent to do so.</p> <p>An improvement is required to ensure three monthly GP medication reviews, evaluation of PRN outcomes, and six monthly controlled drug (CD) stock-take, are completed within the required time frames.</p>
<p>Subsection 3.5: Nutrition to support wellbeing</p> <p>The people: Service providers meet my nutritional needs and consider my food preferences.</p> <p>Te Tiriti: Menu development respects and supports cultural beliefs, values, and protocols around food and access to traditional foods.</p> <p>As service providers: We ensure people's nutrition and hydration</p>	FA	<p>The kitchen service complies with current food safety legislation and guidelines. Meal services are outsourced to an external catering company. There was an approved food plan which expires on 30 April 2023. The menu was reviewed by a registered dietitian on 16 May 2022. Kitchen staff have current food handling certificates.</p> <p>Diets are modified as required and the kitchen staff confirmed awareness of the dietary needs of the residents. Residents have a nutrition profile developed on admission which identifies dietary requirements, likes, and dislikes. Resident dietary profiles were not reviewed six-monthly and dated as required (refer 3.2.5). Residents</p>

<p>needs are met to promote and maintain their health and wellbeing.</p>		<p>are given a choice to select the meals they want on a daily basis. All alternatives are catered for as required. The residents' weights are monitored regularly, and supplements are provided to residents with identified weight loss issues. Snacks and drinks are available for residents throughout the day and night when required.</p> <p>The kitchen and pantry were observed to be clean, tidy, and stocked. Regular cleaning is undertaken, and all services comply with current legislation and guidelines. Labels and dates were on all containers. Thermometer calibrations were completed every three months. Records of temperature monitoring of food, fridges, and freezers are maintained, and these are recorded on the electronic management system.</p> <p>EPOA/whānau/family and residents interviewed indicated satisfaction with the food service.</p> <p>All decanted food had records of use by dates recorded on the containers and no expired items were sighted.</p> <p>The kitchen staff and regional director reported that residents will be offered varied menu options which are culturally specific to te ao Māori where required.</p>
<p>Subsection 3.6: Transition, transfer, and discharge</p> <p>The people: I work together with my service provider so they know what matters to me, and we can decide what best supports my wellbeing when I leave the service.</p> <p>Te Tiriti: Service providers advocate for Māori to ensure they and whānau receive the necessary support during their transition, transfer, and discharge.</p> <p>As service providers: We ensure the people using our service experience consistency and continuity when leaving our services. We work alongside each person and whānau to provide and</p>	<p>FA</p>	<p>There is a documented process in the management of the early discharge/unexpected exit plan and transfer from services. The CM reported that discharges are normally into other similar facilities. Discharges are overseen by the clinical team who manage the process until exit. All this is conducted in consultation with the resident, family/whānau, and other external agencies. Risks are identified and managed as required.</p> <p>A discharge or transition plan will be developed in conjunction with the residents and family/whānau (where appropriate) and documented on the residents' file. Referrals to other allied health providers were completed with the safety of the resident identified. Upon discharge, current and old notes are collated and scanned onto the resident's electronic management system. If a resident's information is required</p>

<p>coordinate a supported transition of care or support.</p>		<p>by a subsequent GP, a written request is required for the file to be transferred.</p> <p>Evidence of residents who had been referred to other specialist services, such as podiatrists, gerontology nurse specialists, and physiotherapists, were sighted in the files reviewed. Residents and EPOA/family/whānau are involved in all exits or discharges to and from the service and there was sufficient evidence in the residents' records to confirm this.</p>
<p>Subsection 4.1: The facility</p> <p>The people: I feel the environment is designed in a way that is safe and is sensitive to my needs. I am able to enter, exit, and move around the environment freely and safely.</p> <p>Te Tiriti: The environment and setting are designed to be Māori-centred and culturally safe for Māori and whānau.</p> <p>As service providers: Our physical environment is safe, well maintained, tidy, and comfortable and accessible, and the people we deliver services to can move independently and freely throughout. The physical environment optimises people's sense of belonging, independence, interaction, and function.</p>	<p>FA</p>	<p>Appropriate systems are in place to ensure the residents' physical environment and facilities (internal and external) are fit for their purpose, are well maintained and that they meet legislative requirements. The building is a single level. A building warrant of fitness expires in June 2023. A maintenance person is employed 20 hours per week.</p> <p>The environment was comfortable and accessible, promoting independence and safe mobility for residents. Water and room temperatures are monitored and are within a safe range. A new wing provides premium rooms, and all rooms are dual use. Rooms are varying sizes to suit residents' needs, including three designated double rooms, currently occupied by one person. Lounges and a conservatory are available. There is sufficient space for residents and family to enjoy a quieter space and to make a drink. Rooms have been individualised with personal items and cultural preferences.</p> <p>Electrical and biomedical testing has been completed for items requiring this.</p> <p>Personalised equipment was available for residents with disabilities to meet their needs. Spaces were culturally inclusive and suited the needs of the various resident groups. There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. All rooms in the new wing offer ensuites while shared facilities are available in the older wing. Two rooms in this wing have ensuites. All have handbasins and most share showers.</p>

		<p>Processes will need to be implemented to ensure that consultation and co-design of the environments occurs, to reflect the aspirations and identity of Māori.</p> <p>The prospective provider stated they have no plans to make changes to the environment in the short term.</p>
<p>Subsection 4.2: Security of people and workforce</p> <p>The people: I trust that if there is an emergency, my service provider will ensure I am safe.</p> <p>Te Tiriti: Service providers provide quality information on emergency and security arrangements to Māori and whānau.</p> <p>As service providers: We deliver care and support in a planned and safe way, including during an emergency or unexpected event.</p>	<p>PA Moderate</p>	<p>Disaster and civil defence planning is guided by policies. These outline the processes necessary to manage disasters and described the procedures to be followed by staff. Staff have been trained and knew what to do in an emergency. The New Zealand Fire Service have approved the fire evacuation plan. A trial evacuation was held in June 2022 with a timely response recorded.</p> <p>Adequate supplies for use in the event of a civil defence emergency meet The National Emergency Management Agency recommendations for the region. Alternative essential energy and utility sources are available, in the event of the main supplies failing.</p> <p>Call bells alert staff to residents requiring assistance, however, shortfalls were identified in this area (see 4.2.5). Appropriate security arrangements are in place. Staff were familiar with emergency and security arrangements.</p>
<p>Subsection 5.1: Governance</p> <p>The people: I trust the service provider shows competent leadership to manage my risk of infection and use antimicrobials appropriately.</p> <p>Te Tiriti: Monitoring of equity for Māori is an important component of IP and AMS programme governance.</p> <p>As service providers: Our governance is accountable for ensuring the IP and AMS needs of our service are being met, and we participate in national and regional IP and AMS programmes and respond to relevant issues of national and regional concern.</p>	<p>FA</p>	<p>The infection prevention (IP) and antimicrobial stewardship (AMS) programmes are appropriate to the size and complexity of the service, have been approved, and links to the quality improvement system. IPC data is reported monthly by the GM using a comprehensive key indicator reporting template. This is also the pathway to report and escalate significant infection related issues to the governing body. Investigation of outbreaks is documented. This has supported appropriate cohorting of residents and staff, as necessary. Trends are discussed and follow up action undertaken, including any training necessary. There are low rates of facility acquired infections.</p> <p>The IP manual and annual programme detail defined processes for reporting of issues and for accessing expertise and advice which has been sought from the DHB infection prevention team. The service has</p>

		<p>also included regular updates through virtual meetings amongst the regional ARC collective throughout the pandemic. This has been an effective means to communicate with the sector and introduce any changes in practice required.</p>
<p>Subsection 5.2: The infection prevention programme and implementation</p> <p>The people: I trust my provider is committed to implementing policies, systems, and processes to manage my risk of infection.</p> <p>Te Tiriti: The infection prevention programme is culturally safe. Communication about the programme is easy to access and navigate and messages are clear and relevant.</p> <p>As service providers: We develop and implement an infection prevention programme that is appropriate to the needs, size, and scope of our services.</p>	<p>FA</p>	<p>The service has a documented infection prevention and control programme that is reviewed annually. A review of the programme is completed by the regional manager in consultation with the care managers from the other sister facility. The CM is the infection prevention coordinator (IPC). A position description for the IPC was in place and this was sighted on the audit day.</p> <p>Mossbrae Lifecare has guidelines in place to manage and prevent exposure to infections. Infection prevention and control training is provided to staff, residents, and visitors. There were adequate supplies of personal protective equipment (PPE) and hand sanitisers in stock. Hand washing audits were completed as per schedule. Policies and procedures are documented and reviewed regularly. Staff are advised not to attend work if they are unwell or self-isolate and get tested if they have been in contact with a person who has tested positive for COVID-19. Most residents and all staff were vaccinated for COVID-19 and influenza. Completed records were sighted in all files sampled.</p> <p>A pandemic/infectious diseases response plan is documented and has been regularly tested. There are sufficient resources and personal protective equipment (PPE) available, and staff have been trained accordingly. The facility has followed MoH guidance and NZ Aged Residential Care Association guidance during the pandemic. Information and resources to support staff in managing COVID-19 were regularly updated. Visitor screening and residents' temperature monitoring records depending on alert levels by the MOH were documented. COVID -19 rapid antigen tests (RATs) are being conducted for staff and visitors when indicated before coming on site.</p> <p>There was an exposure event due to Covid-19, in April and June 2022 where 32 residents were affected, and norovirus in June 2022, and both events were managed according to policy. The facility was</p>

		<p>closed to the public, with GP, EPOA/whānau/family, residents, and relevant authorities notified promptly. Documented evidence of meetings with DHB, staff, and EPOA/whānau/family notifications were sighted.</p> <p>Infection control policy sighted was updated to include COVID-19 and disinfection/decontamination of reusable medical devices. Documented policies and procedures for managing both manual and automated decontamination of reusable medical devices were reviewed. The CM reported that there are documented appropriate decontamination procedures in place for medical equipment and devices used in the delivery of care. Internal audits are completed three times a year and all corrective actions are documented and verified at the audit. The CM interviewed reported that cultural advice is accessed through the DHB and other linkages in the community.</p> <p>The service has documented policies and procedures in place that reflected current best practices. Policies and procedures are accessible and available for staff in the nurses' station and these were current. Care delivery, cleaning, laundry, and kitchen staff were observed following organisational policies, such as appropriate use of hand sanitizers, good hand washing technique, and use of disposable aprons and gloves. Staff demonstrated knowledge of the requirements of standard precautions and were able to locate policies and procedures.</p> <p>Staff training on infection prevention and control is routinely provided during orientation and annual in-service education (refer 2.4.4). In-service education is conducted by either the CM, or other external consultants. The infection training includes handwashing procedures, donning and doffing protective equipment, and regular Covid-19 updates. Records of staff education were maintained. The IPC completed the required infection control training.</p> <p>The service is actively working towards including infection prevention information in te reo Māori. They are also working towards ensuring that the infection prevention personnel and committee work in partnership with Māori for the protection of culturally safe practices in</p>
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		infection prevention and acknowledging the spirit of Te Tiriti.
<p>Subsection 5.3: Antimicrobial stewardship (AMS) programme and implementation</p> <p>The people: I trust that my service provider is committed to responsible antimicrobial use.</p> <p>Te Tiriti: The antimicrobial stewardship programme is culturally safe and easy to access, and messages are clear and relevant.</p> <p>As service providers: We promote responsible antimicrobials prescribing and implement an AMS programme that is appropriate to the needs, size, and scope of our services.</p>	FA	<p>Mossbrae Lifecare is committed to responsible use of antimicrobials. The effectiveness of the AMS programme is evaluated by monitoring antimicrobial use and identifying areas for improvement. The CM is responsible for implementing the infection control programme and indicated there are adequate people, physical, and information resources to implement the programme. Infection control reports are completed monthly, and these are discussed at management and staff meetings. Staff confirmed that infection rates information is shared in a timely manner. The IPC has access to all relevant residents' data to undertake surveillance, internal audits, and investigations, respectively. Specialist support can be accessed through the district health board, the medical laboratory, and the attending GP.</p>
<p>Subsection 5.4: Surveillance of health care-associated infection (HAI)</p> <p>The people: My health and progress are monitored as part of the surveillance programme.</p> <p>Te Tiriti: Surveillance is culturally safe and monitored by ethnicity.</p> <p>As service providers: We carry out surveillance of HAIs and multi-drug-resistant organisms in accordance with national and regional surveillance programmes, agreed objectives, priorities, and methods specified in the infection prevention programme, and with an equity focus.</p>	FA	<p>Surveillance of health care-associated infections (HAIs) is appropriate to that recommended for long term care facilities and is in line with priorities defined in the infection control programme. The data is collated and analysed monthly to identify any significant trends or common possible causative factors. Results of the surveillance data are shared with staff during shift handovers, at monthly staff meetings, and quality/management meetings. All infection data is compiled, documented and reported to the regional clinical manager. Evidence of completed infection control audits were sighted.</p> <p>Staff interviewed confirmed that they are informed of infection rates as they occur. The GP was informed on time when a resident has an infection and appropriate antibiotics were prescribed for all diagnosed infections.</p> <p>The service is actively working towards ensuring surveillance of healthcare-associated infections include ethnicity data.</p>
<p>Subsection 5.5: Environment</p> <p>The people: I trust health care and support workers to maintain a hygienic environment. My feedback is sought on cleanliness</p>	FA	<p>The service policy describes safe and appropriate storage and disposal of waste, and infectious or hazardous substances, including storage and use of chemicals. Material safety data sheets were available where chemicals are stored, and staff interviewed knew</p>

<p>within the environment.</p> <p>Te Tiriti: Māori are assured that culturally safe and appropriate decisions are made in relation to infection prevention and environment. Communication about the environment is culturally safe and easily accessible.</p> <p>As service providers: We deliver services in a clean, hygienic environment that facilitates the prevention of infection and transmission of antimicrobial resistant organisms.</p>		<p>what to do should any chemical spill/event occur. No hazardous substances were detected on site. All staff interviewed demonstrated awareness of safety and appropriate disposal of waste. Used continence and sanitary products are disposed of appropriately in disposal containers stored in a safe place outside.</p> <p>There were sharps boxes in the medication room. Personal protective equipment (PPE) including gloves, aprons, and goggles are available for staff throughout the facility. Staff was observed to be using personal protective equipment, including changing gloves after every procedure.</p> <p>All laundry is washed on-site, or by family members if requested, in the well-equipped laundry which has a clear separation of clean and dirty areas. The resident and family/ whānau interviewed expressed satisfaction with the laundry management and reported that the clothes are returned promptly. There are designated laundry and cleaning staff. All have received appropriate annual training in chemical safety and infection control, including COVID-19. Chemicals were decanted into appropriately labelled containers. Chemicals are stored in labelled containers in the locked storeroom. There are cleaning rooms where all cleaning trollies are kept locked. Safety data sheets were available in the laundry, kitchen, sluice rooms, and chemical storage areas.</p> <p>The effectiveness of cleaning and laundry processes is monitored through the internal audit programme and corrective actions are acted upon. Cleaning of frequently touched areas and accessed areas was increased due to COVID-19. The residents and family members interviewed reported that the environment was clean. The care staff demonstrated a sound knowledge of the laundry processes.</p>
<p>Subsection 6.1: A process of restraint</p> <p>The people: I trust the service provider is committed to improving policies, systems, and processes to ensure I am free from restrictions.</p>	<p>FA</p>	<p>The GM reports to governance on any restraint using the monthly reporting template. Restraint use is also discussed at the quality, health and safety and IP meetings. Minutes were reviewed. At the time of audit, one resident was recorded to be using a restraint (bedrail), which is the only approved restraint for those unable to consent to a safety intervention. Historically, combined records of</p>

<p>Te Tiriti: Service providers work in partnership with Māori to ensure services are mana enhancing and use least restrictive practices.</p> <p>As service providers: We demonstrate the rationale for the use of restraint in the context of aiming for elimination.</p>		<p>restraint have mostly related to enabler use. Presently, a hard copy register is used to record episodes of restraint – there have been four entries recorded in the past 12 months, with all except one relating to enabler use.</p> <p>When restraint is used, the documentation requirements are on residents’ file (both hard copy and electronic). Whānau/EPOA were involved in decision making. There are processes to monitor and report restraint use when implemented.</p> <p>Policies are in place but will require updating to reflect the changes in the standard. The restraint coordinator role provides support and oversight for any restraint management. Staff have been trained in communication, cultural considerations and de-escalation. Staff undertaking New Zealand Qualification Authority unit standard based level 3 have also received training in restraint.</p>
<p>Subsection 6.2: Safe restraint</p> <p>The people: I have options that enable my freedom and ensure my care and support adapts when my needs change, and I trust that the least restrictive options are used first.</p> <p>Te Tiriti: Service providers work in partnership with Māori to ensure that any form of restraint is always the last resort.</p> <p>As service providers: We consider least restrictive practices, implement de-escalation techniques and alternative interventions, and only use approved restraint as the last resort.</p>	<p>FA</p>	<p>Assessments for the use of restraint, monitoring and evaluation were documented and included all requirements of the Standard. Whānau confirmed their involvement. Access to advocacy is facilitated, as necessary. Restraint, when required, is used safely. Alternatives to restraint use are trialled and the least restrictive means used.</p> <p>Documentation of restraint use included assessment, monitoring requirements and reviews which are included in the electronic resident record. Discussion with family/whānau is recorded. Each episode of restraint is evaluated. A restraint register is maintained and reviewed at each six-monthly restraint review. The register contained enough information to provide an auditable record. Records indicated that restraint was discontinued when no longer required.</p> <p>There has been no debriefing required as a result of emergency restraint use.</p>
<p>Subsection 6.3: Quality review of restraint</p> <p>The people: I feel safe to share my experiences of restraint so I</p>	<p>FA</p>	<p>The restraint committee undertakes a six-monthly review of all restraint used to reflect the requirements of the Standard. The outcome of the review is reported to the governance body. Any changes to policies, guidelines, education and processes are</p>

<p>can influence least restrictive practice.</p> <p>Te Tiriti: Monitoring and quality review focus on a commitment to reducing inequities in the rate of restrictive practices experienced by Māori and implementing solutions.</p> <p>As service providers: We maintain or are working towards a restraint-free environment by collecting, monitoring, and reviewing data and implementing improvement activities.</p>		<p>implemented if indicated. The use of restraint has been reduced over the past year, with only one person using a bedrail. This has been a long term intervention.</p>
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Specific results for criterion where corrective actions are required

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

Criterion can be linked to the relevant subsection by looking at the code. For example, Criterion 1.1.1 My service provider shall embed and enact Te Tiriti o Waitangi within all its work, recognising Māori, and supporting Māori in their aspirations, whatever they are (that is, recognising mana motuhake) relates to subsection 1.1: Pae ora healthy futures in Section 1 Our rights.

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 2.3.1</p> <p>Service providers shall ensure there are sufficient health care and support workers on duty at all times to provide culturally and clinically safe services.</p>	PA Low	<p>Staffing levels have been difficult to maintain throughout the Covid-19 pandemic, during the national staffing shortages in addition to staff illness and turnover. Historically the service has relied on overseas staff and on occasion, a student workforce. Overseas recruitment has continued, and appointments made. Some delays occur through the visa process, however staffing numbers are increasing, and shifts are being permanently filled from August.</p> <p>Over the past eighteen months, section 31 notices have been submitted to the DHB for to notify any roster shortfalls.</p>	<p>A sample of rosters over three weeks in June and July 2022 (including one weekend) indicates that six shifts remained unfilled (primarily afternoons or night shifts). Risk is mitigated with judicious use of senior medication competent trained caregivers, and some staff working extended shifts to cover shortfalls. The situation is improving with successful recruitment achieved, which will see further staff commencing in permanent positions at Mossbrae over the next month.</p>	<p>Take sustainable action to ensure there are sufficient health care and support workers on duty at all times to provide culturally and clinically safe services.</p> <p>180 days</p>

<p>Criterion 2.4.1</p> <p>Service providers shall develop and implement policies and procedures in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Moderate</p>	<p>There are implemented processes for police vetting when appointing new staff. Since 2020, records of completed police vetting are on file (although not prior to this time). As yet, there is no process to undertake police re-vetting of staff. The prospective purchaser (in attendance) confirms it is their practice to re-vet all currently employed staff.</p> <p>Registered and enrolled nurses, some healthcare assistants and a diversional therapist undertake first aid and cardiopulmonary resuscitation in two split sessions, last held in October and November 2021. Of the eleven staff, five have completed both sessions, with the remaining six are still to undertake one module.</p>	<p>A sample of four staff files of those employed prior to 2020, have no records of police vetting or equivalent process on the individual files. There is no process of re-vetting following a period of employment.</p> <p>Not all RN's employed to provide clinical care have fully completed first aid certificate updates.</p>	<p>Implement processes aligned with good employment practice and meet the requirements of legislation</p> <p>90 days</p>
<p>Criterion 2.4.4</p> <p>Health care and support workers shall receive an orientation and induction programme that covers the essential components of the service provided.</p>	<p>PA Low</p>	<p>A system for new staff to complete an orientation package is in place. This has been delayed during the pandemic disruptions. A plan is in place to complete this backlog later in July dates booked. In a sample of staff files, five of six new staff employed since 2021 have yet to complete all aspects of their orientation. Newer staff interviewed stated that this would have supported them to better understand their role. This was also an area for improvement at the last audit mapped to 1.2.7.4 (New providers receive an orientation that covers the essential components of the service).</p>	<p>In a sample of staff files, five of six new staff employed since 2021 have yet to complete all aspects of their orientation. This was an area for improvement at the last audit.</p>	<p>Complete an orientation programme for all new staff who did not complete this on employment.</p> <p>180 days</p>

<p>Criterion 2.4.5</p> <p>Health care and support workers shall have the opportunity to discuss and review performance at defined intervals.</p>	<p>PA Low</p>	<p>There is a system for undertaking and recording performance appraisals annually, with these now linked to competency updates. Inspection of records identified variability in completion of both the competencies and annual appraisal now scheduled to occur at the same time. A corrective action plan is in place and progress is being made to address this.</p> <p>This was also identified at the previous audit and is mapped to 1.2.7.5 (A system to identify, plan and record ongoing training).</p>	<p>At the time of audit, approximately 20% of appraisals and associated competencies remain overdue.</p>	<p>Complete performance appraisals and competency updates annually.</p> <p>180 days</p>
<p>Criterion 3.2.5</p> <p>Planned review of a person's care or support plan shall:</p> <p>(a) Be undertaken at defined intervals in collaboration with the person and whānau, together with wider service providers;</p> <p>(b) Include the use of a range of outcome measurements;</p> <p>(c) Record the degree of achievement against the person's agreed goals and aspiration as well as whānau goals and aspirations;</p> <p>(d) Identify changes to the person's care or support plan, which are agreed</p>	<p>PA Moderate</p>	<p>There were 31 overdue interRAI re-assessments ranging from seven 14 to 324 days. The CM reported that the service was granted a waiver by the ministry (MoH) on interRAI re-assessments which lasted until the end of July 2022. Nine (9) recent residents' admission interRAI assessments were not completed in a timely manner, and these were not included in the waiver set conditions and needed to be completed. Some outcome scores from interRAI assessments such as pain, falls, behaviour, nutrition were not identified on the long term care plans and relevant interventions developed. Resident dietary profiles were not reviewed six-monthly and dated as required. The CM reported that the service was actively working towards completing all overdue interRAI re-assessments and ensuring all triggers are identified on long term care plans. Resident,</p>	<p>Not all outcome scores from interRAI assessments were identified on long term care plans and there were no appropriate interventions to address these.</p> <p>Resident dietary profiles were not reviewed six-monthly and dated as required.</p> <p>Nine (9) recent residents' interRAI assessments not covered by the waiver from MOH were not completed in a timely manner.</p>	<p>Ensure all outcome scores from assessments are identified with relevant interventions developed.</p> <p>Complete resident dietary profiles six-monthly with dates recorded on them as per policy requirements.</p> <p>Ensure all new interRAI assessments excluded from the waiver are completed within the required timeframes.</p>

<p>collaboratively through the ongoing re-assessment and review process, and ensure changes are implemented; (e) Ensure that, where progress is different from expected, the service provider in collaboration with the person receiving services and whānau responds by initiating changes to the care or support plan.</p>		<p>family/whānau/EPOA, and GP involvement is encouraged. The outcomes scores not identified on the long term care plans had the potential of putting the residents at safety risks for example, pain, falls, nutrition and behavioural risks. These needed to be identified and detailed interventions developed to guide staff.</p>		<p>90 days</p>
<p>Criterion 3.4.2 The following aspects of the system shall be performed and communicated to people by registered health professionals operating within their role and scope of practice: prescribing, dispensing, reconciliation, and review.</p>	<p>PA Moderate</p>	<p>A safe system for medicine management (an electronic system) is in use. This is used for medication prescribing, dispensing, administration, review, and reconciliation. Administration records are maintained. Medications are supplied to the facility from a contracted pharmacy. The GP completes three monthly reviews, however eight (8) medication charts were not reviewed within the required timeframes as per policy and legislative requirements, with timeframes ranging from March 2022 to July 2022.</p> <p>The CM interviewed reported that discussions were initiated with the responsible GPs to have these medication charts reviewed and this was also identified in previous internal audits conducted.</p>	<p>Three monthly GP medication reviews were not completed within the required timeframes with eight (8) medicine charts overdue.</p>	<p>Ensure three-monthly medication reviews are completed as per policy and legislative requirements.</p> <p>90 days</p>
<p>Criterion 3.4.3</p>	<p>PA</p>	<p>There were no expired or unwanted medicines. Controlled drugs are kept in</p>	<p>Six-monthly CD stocktakes were not completed in both wings as per</p>	<p>Ensure six-monthly CD stock-takes are</p>

<p>Service providers ensure competent health care and support workers manage medication including: receiving, storage, administration, monitoring, safe disposal, or returning to pharmacy.</p>	<p>Moderate</p>	<p>both wing's double locked cupboards. Weekly stocktakes were completed in both wings, however six-monthly stock takes were not completed according to policy and legislative requirements. Expired medicines are returned to the pharmacy promptly. Monitoring of medicine fridge and medication room temperatures were completed as per policy requirements.</p> <p>Medication competencies were current and these were completed in the last 12 months for all staff administering medicines. Medication incidents were completed in the event of a drug error and corrective actions were acted upon. A sample of these was reviewed during the audit. Outcomes in 16 PRN resident medicine charts sampled were not consistently documented for effectiveness; this included medicines such as laxatives, pain relief, and sleeping tablets.</p>	<p>policy and legislative requirements. 16 medicine charts sampled did not have a consistent evaluation of the administered PRN medicines.</p>	<p>completed as per policy and legislative requirements. Ensure outcomes of PRN medicines are consistently documented for effectiveness.</p> <p>90 days</p>
<p>Criterion 4.2.5 An appropriate call system shall be available to summon assistance when required.</p>	<p>PA Moderate</p>	<p>Concerns in relation to response times remain an issue and have featured in complaints in the past two years, including one HDC complaint. The present system does not provide a call history to evidence that call bells are consistently responded to in an acceptable time. Audits were undertaken in February and March 2021, but this relied on anecdotal evidence reported by residents/whānau and this audit has not been maintained. Timely response to call bells cannot be demonstrated.</p> <p>On the day of audit, the audible sound was</p>	<p>The call system does not meet the needs of residents and timely responses to call bells cannot be demonstrated.</p> <p>There is no light visible outside the Argyle lounge when the call bell is activated and no way to alert staff of the call without reference to a distant indicator board.</p> <p>Residents are not consistently left with their call bell within reach.</p>	<p>Implement measures which ensures the call system meets the needs of residents and that timely staff responses to call bells can be demonstrated.</p> <p>90 days</p>

		<p>not working in Argyle wing. This was successfully repaired at the time. Indicator boards are located in key areas, with a display light outside the room where the call was initiated.</p> <p>There is a recent incident of a resident left on a commode for an extended period, without access to their call bell.</p> <p>Family/whānau interviewed commented that they have observed delays in staff response to call bells</p>		
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Specific results for criterion where a continuous improvement has been recorded

As well as whole subsections, individual criterion within a subsection 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 subsection by looking at the code. For example, Criterion 1.1.1 relates to subsection 1.1: Pae ora healthy futures in Section 1: Our rights.

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

No data to display

End of the report.