Mary Doyle Healthcare Limited - Mary Doyle Lifecare

Introduction

This report records the results of a Surveillance 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 BSI Group New Zealand Ltd, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to Manatū Hauora (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 Manatū Hauora website by clicking here.

The specifics of this audit included:

Legal entity:	Mary Doyle Healthcare Limited
Premises audited:	Mary Doyle Lifecare
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 12 December 2023 End date: 13 December 2023

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 100

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 tātou 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 haumaru │ person-centred and safe environment
- te kaupare pokenga me te kaitiakitanga patu huakita │ infection prevention and antimicrobial stewardship
- here taratahi │ restraint and seclusion.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the subsection in each of the sections. 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 subsections applicable to this service are fully attained with some subsections exceeded
	No short falls	Subsections applicable to this service are fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some subsections applicable to this service are partially attained and of low risk

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some subsections applicable to this service are 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 subsections applicable to this service are unattained and of moderate or high risk

General overview of the audit

Mary Doyle Lifecare is owned and operated by the Arvida Group. The service is certified to provide care for up to 161 residents at rest home and hospital (medical and geriatric) and dementia level of care. On the day of the audit there were 100 residents in total.

This surveillance audit was conducted against a subset of the Ngā Paerewa Health and Disability Services Standard 2021 and contracts with Te Whatu Ora Health New Zealand -Te Matau a Māui Hawke's Bay. The audit process included the review of policies and procedures, the review of resident and staff files, observations, and interviews with residents, family/whānau, the nurse practitioner, management and staff.

The village manager and acting clinical manager are appropriately qualified and experienced in aged care. They are supported by a senior clinical coordinator, group of registered nurses, enrolled nurses, and wellness partners. Feedback from residents and families/ whānau was positive about the care and the services provided. An induction and in-service training programme are in place to provide staff with appropriate knowledge and skills to deliver care.

The service has addressed nine of the ten previous surveillance shortfalls relating to the implementation of the quality system, interRAI timeframes, medication management, restraint competencies, annual appraisals, and implementation of infection control policies.

Improvements continue to be required around updating care plan.

This surveillance audit identified areas for improvement are required around care plans interventions and hot water monitoring.

Ō tātou motika | Our rights

Includes 10 subsections that support an outcome where people receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of people's rights, facilitates informed choice, minimises harm, and upholds cultural and individual values and beliefs.		Subsections applicable to this service are fully attained.

There is a Māori health plan and a Pacific health plan documented. The service ensures that all residents and family/whanau are informed of their rights. There are documented policies that protect residents from abuse. Informed consent processes were discussed with residents and family/whanau on admission. Complaints processes are implemented in accordance with the guidelines set by the Health and Disability Commissioner.

Hunga mahi me te hanganga | Workforce and structure

Includes five subsections that support an outcome where people receive quality services through effective governance and a supported workforce.		Subsections applicable to this service are fully attained.

The 2023 business plan includes a mission statement and operational objectives. The service has effective quality and risk management systems in place that take a risk-based approach, and these systems meet the needs of residents and their staff. Quality improvement projects are implemented. Internal audits, meetings, and collation of data were all documented as taking place as scheduled, with corrective actions as indicated. There is a staffing and rostering policy. Human resources are managed in accordance with good employment practice. A role specific orientation programme and regular staff education and training are in place.

Ngā huarahi ki te oranga | Pathways to wellbeing

Includes eight subsections that support an outcome where people participate in the development of their pathway to wellbeing, and receive timely assessment, followed by services that are planned, coordinated, and delivered in a manner that is tailored to their needs.		Some subsections applicable to this service are partially attained and of medium or high risk and/or unattained and of low risk.

The registered nurses assess, plan and review residents' needs, outcomes, and goals with the resident and/or family/whānau input. Care plans demonstrate service integration. Resident files included medical notes by the contracted nurse practitioner and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. All staff responsible for administration of medication complete education and medication competencies. The electronic medicine charts reviewed met prescribing requirements and were reviewed at least three-monthly by the nurse practitioner.

The kitchen staff cater to individual cultural and dietary requirements. The service has a current food control plan. Nutritional snacks are available for residents 24 hours. Residents were complimentary of the food services.

All residents’ transfers and referrals are coordinated with residents and families/whānau

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

Includes two subsections that support an outcome where Health and disability services are provided in a safe environment appropriate to the age and needs of the people receiving services that facilitates independence and meets the needs of people with disabilities.		Some subsections applicable to this service are partially attained and of low risk.

The building has a current warrant of fitness and an approved fire evacuation scheme. There is a planned and reactive maintenance programme in place. Equipment is maintained for electrical compliance and clinical equipment is regularly calibrated.

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

Includes five subsections that support an outcome where Health and disability service providers' infection prevention (IP) and antimicrobial stewardship (AMS) strategies define a clear vision and purpose, with quality of care, welfare, and safety at the centre. The IP and AMS programmes are up to date and informed by evidence and are an expression of a strategy that seeks to maximise quality of care and minimise infection risk and adverse effects from antibiotic use, such as antimicrobial resistance.		Subsections applicable to this service are fully attained.

There is a documented infection control programme that includes pandemic plan and outbreak management plan. The infection control programme links to the quality programme. Staff receive regular education related to infection control.

The type of surveillance undertaken is appropriate to the size and complexity of the organisation. There is an infection control committee that meets bimonthly; monthly infection control data is presented and discussed at the monthly quality improvement meetings. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated, and reported to relevant personnel in a timely manner. Benchmarking occurs.

Laundry processes are implemented and monitored for compliance.

Here taratahi | Restraint and seclusion

Includes four subsections that support outcomes where Services shall aim for a restraint and seclusion free environment, in which people's dignity and mana are maintained.		Subsections applicable to this service are fully attained.

The restraint coordinator is a registered nurse. The facility had no residents using restraint at the time of audit. Encouraging a restraint-free environment is included as part of the education and training plan. The service considers least restrictive practices, implementing de-escalation techniques and alternative interventions, and only uses an approved restraint as the last resort

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	18	0	1	1	0	0
Criteria	0	50	0	2	1	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.

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
Subsection 1.1: Pae ora healthy futures Te Tiriti: Māori flourish and thrive in an environment that enables good health and wellbeing. 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.	FA	A Māori health plan is documented for the service. This policy acknowledges Te Tiriti o Waitangi as a founding document for New Zealand and the provision of services based on the principles of mana motuhake. Seventeen care staff (eight wellness partners (caregivers), five wellness leaders (activities) and four registered nurses [RNs]) interviewed explained how residents are involved in providing input into their care, their activities, and their dietary needs. The service currently has residents who identify as Māori.
Subsection 1.2: Ola manuia of Pacific peoples in Aotearoa The people: Pacific peoples in Aotearoa are entitled to live and enjoy good health and wellbeing. Te Tiriti: Pacific peoples acknowledge the mana whenua of Aotearoa as tuakana and commit to supporting them to achieve tino rangatiratanga. 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.	FA	The Pacific Way Framework (PWC) is the chosen model for the Pacific health plan; Arvida Ola Manuia plan is in place. The aim is to uphold the principles of Pacific people by acknowledging respectful relationships and embracing cultural and spiritual beliefs and providing high quality healthcare. There were no residents identified as Pasifika in the care centre. Staff have received training in cultural safety and introduction to the PWC.

Subsection 1.3: My rights during service delivery The People: My rights have meaningful effect through the actions and behaviours of others. Te Tiriti:Service providers recognise Māori mana motuhake (self-determination). As service providers: We provide services and support to people in a way that upholds their rights and complies with legal requirements.	FA	The Code of Health and Disability Services Consumers' Rights (the Code) is displayed in English and te reo Māori. Six residents (five rest home residents and one hospital resident) and six family/whānau (three rest home, two dementia and one hospital) reported that all staff respected their rights, that they were supported to know and understand their rights. Care plans reviewed were resident centred and evidenced input into their care and their choice/independence are respected. Staff have completed training on the Code of Rights.
Subsection 1.5: I am protected from abuse The People: I feel safe and protected from abuse. Te Tiriti: Service providers provide culturally and clinically safe services for Māori, so they feel safe and are protected from abuse. As service providers: We ensure the people using our services are safe and protected from abuse.	FA	Arvida Mary Doyle policies prevent any form of discrimination, coercion, harassment, or any other exploitation. Cultural days are held to celebrate diversity. A staff code of conduct is discussed during the new employee's induction to the service. The code of conduct addresses harassment, racism, and bullying. Staff sign to acknowledge that they accept the code of conduct as part of the employment process. Professional boundaries are defined in job descriptions. Staff interviews (17 care staff, kitchen manager, laundry assistant and grounds and maintenance supervisor) confirmed their understanding of professional boundaries, including the boundaries of their role and responsibilities. Professional boundaries are covered as part of orientation. Staff complete education on orientation and annually as per the training plan on how to identify abuse and neglect. Staff are educated on how to value the older person, showing them respect and dignity. The residents and families/whānau interviewed confirmed that the staff are very caring, supportive, and respectful. The service implements a process to manage residents' comfort funds, such as sundry expenses.
Subsection 1.7: I am informed and able to make choices 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.	FA	There are policies around informed consent that include best tikanga practice. Family/whanau interviewed stated they are provided with choice when treatment is discussed. The informed consent process follows the guidelines of the Code of Health and Disability Services Consumers' Rights. Staff completed education in Code of Rights. Files reviewed had all

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. 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.		completed informed consent documents on file. Enduring power of attorney (EPOA) is activated for residents where required. There are letters of mental capacity on file for the residents in the dementia unit.
Subsection 1.8: I have the right to complain The people: I feel it is easy to make a complaint. When I complain I am taken seriously and receive a timely response. 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. 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.	FA	The complaints procedure is provided to residents and family/ whānau during the resident's entry to the service. A complaints management policy includes information on access to advocacy and complaint support systems. The Code of Health and Disability Services Consumers' Rights is visible, and available in te reo Māori, and English. Discussions with residents and family/whānau confirmed that they were provided with information on the complaints process and remarked that any concerns or issues they had, have been addressed promptly. The village manager is responsible for the management of complaints and provides Māori residents with support to ensure an equitable complaints process. A complaints register is being maintained. There were complaints lodged since the last audit. One complaint related to an incident in October 2021 was lodged in February 2022 with Te Whatu Ora – Health New Zealand Te Matau a Māui Hawkes Bay, this has triggered an issue-based audit completed by TAS and recommendations were made related to employment practices. Reporting on the action plan (reviewed) related to the recommendations were reported on in July, August and November 2023. The funder regularly follows up on the implementation of the action plan. The complaint remains open till the funder is satisfied. Two other complaints remain open and include: one complaint received from the Plastic Surgery department at Te Whatu Ora –Te Matau a Māui Hawkes Bay related to transfer to an appointment of a resident with dementia. The service is in the process of reviewing the transfer and movement policy. A serious complaint made in December 2023 related to alleged abuse is still open and pending full investigation. The complaints reviewed evidence no identified trends. Follow up and resolution letters link

		to the national advocacy service. Complaints were followed up and resolution occurred to the satisfaction of the complainant and within the timeframes and guidelines of the Health and Disability Commissioner (HDC).
Subsection 2.1: Governance The people: I trust the people governing the service to have the knowledge, integrity, and ability to empower the communities they serve. 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. As service providers: Our governance body is accountable for delivering a highquality service that is responsive, inclusive, and sensitive to the cultural diversity of communities we serve.	FA	Mary Doyle Lifecare is part of the Arvida Group. The service is certified to provide rest home, hospital (medical and geriatric), and dementia level care for up to 161 residents. On the day of the audit there were 100 residents: 31 rest home residents, 34 hospital level residents, and 35 residents at dementia level of care including one resident on a long-term support-chronic health contract (LTS-CHC). The remaining residents were under the age-related residential care contract (ARRC). The service is divided across five separate units; two dementia units (64 beds including Ashcroft with 34 beds, and Goddard (A and B wings); one rest home only unit (Bramlee with 34 beds); and two dual-purpose units (Reeve with 37 beds and Nimon with 23 beds). There are three serviced apartments certified to provide rest home level care, noting that these were not occupied on the day of audit. There are no double or shared rooms. At the time of the audit, 23 beds in Nimon household were temporarily closed with the last resident having been re-homed in November 2023 and 16 dementia beds in B wing of Goddard household remain closed. Arvida Group has a well-established organisational structure. The provision of care and support services is under the remit of the wellness and care team. This group provides support and leadership across all communities and is firmly engaged with the values and approach, with its emphasis on the ‘Attitude of Living Well’ (moving, eating, thinking, engaging and resting well). Arvida Group have a quality assurance and risk management programme and an operational business plan. The Arvida Living Well Community 2023 business plan is specific to Arvida Mary Doyle and describes specific and measurable goals that are regularly reviewed and updated. Site specific goals relates to clinical effectiveness, risk management and financial compliance. Quality improvements are documented around environmental improvements, communication pathways, and delivering a food experience. The business plan describes annual goals and objectives that support outcomes to achieve equity for

		Māori and addressing barriers for Māori. Cultural safety is embedded within the documented quality programme and staff training. There are various groups in the support office who provide oversight and support to village managers. Village managers have overall responsibility, authority, and accountability for service provision at the village. Each village manager has a support partner that provides mentoring and reports through to the senior leadership, executive team, and the Board. Arvida Group ensure the necessary resources, systems and processes are in place that support effective governance. The Board receives progress updates on various topics, including benchmarking, escalated complaints, human resource matters and occupancy. The establishment of a Māori and health equity advisory group provide guidance in identifying barriers to improve outcomes for Māori and to achieve equitable service delivery. There is a village manager (non-clinical) that oversees the operational, financial management, HR management, property, and maintenance requirements. The village manager has previously managed aged care facilities and has been in the role since November 2022. The village manager is supported by acting/contract clinical manager that had been in the role for three months and a senior clinical coordinator who oversee the clinical governance for the facility. The clinical manager role is currently advertised. There is a clinical governance structure and includes the Clinical Governance Group with links to the Māori and Health Equity Advisory groups and the Clinical Indicator Steering groups. The Clinical governance group ensures a co-ordinated approach to ensure the standards are met. Reports from the Clinical Governance Group are incorporated into regular reports to the chief executive officer (CEO) The Head of Wellness and Compliance and the Head of Clinical Quality closely supported the facility over the last year to oversee quality improvement activities. The village manager and acting clinical manager have completed a two-day managers forum including leadership and strategy topics related to aged care.
Subsection 2.2: Quality and risk	FA	Arvida Mary Doyle has a documented quality and risk management programme. The documented quality and risk management system

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. Te Tiriti: Service providers allocate appropriate resources to specifically address continuous quality improvement with a focus on achieving Māori health equity. 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.		includes performance monitoring through internal audits and through the collection of clinical indicator data. Bimonthly quality and infection control meetings, monthly health and safety meetings, monthly clinical meetings, quarterly full staff meetings and monthly household staff meetings provide an avenue for discussions in relation to (but not limited to): quality data; health and safety; infection control/pandemic strategies; complaints received (if any); cultural compliance; internal audit results and corrective actions; staffing; and education. Internal audits and collation of data were documented as taking place, with corrective actions documented where indicated to address service improvements. Corrective action plans document evidence of progress and are signed off in a timely manner. There was a noticeable pattern of improvement in quality documentation. Evidence of results of internal audits, interviews with staff and meeting minutes reviewed evidence improvement in quality activities. There was evidence that staff are informed of quality data trends, analysis, and a recent outcome from a staff satisfaction survey. The previous audit findings 2.2.1 and 2.2.4 related to implementation of meeting minutes, subsequent corrective actions, and the reporting of quality data to staff has now been addressed. There are procedures to guide staff in managing clinical and non-clinical emergencies. A document control system is in place. Policies are regularly reviewed, with several policies in the process of being reviewed. A Māori consultant supports the review of policies. A recent resident and family/whānau satisfaction survey was completed with a high response rate recorded. The responses of the survey were still being collated at the time of the audit. A preliminary result related to the likelihood of respondents to recommend the facility was made available to the auditors (with a comparison with the 2021). The result evidence an improvement from 2021 (note there was no survey for 2022). Resident and family/whānau are provided opportunities for feedback at monthly household meetings and bimonthly family/whānau meetings in each household (meetings sighted). The previous finding related to resident and family/whānau satisfaction survey and the family/whānau meetings have now been met. A health and safety system is in place. There is a health and safety committee with representatives from each department that meets three-monthly. Hazard identification forms are completed electronically, and an

		up-to-date hazard register was reviewed. Health and safety policies are implemented and monitored by the health and safety committee. There are regular meetings with the national health and safety manager. Staff incident, hazards and risk information is collated at a facility level, reported to national level and a consolidated report and analysis of all facilities are then provided to the governance body. In the event of a staff accident or incident, a debrief process is documented on the accident/incident form. There were no serious staff injuries in the last 12 months. Electronic reports are completed for each incident/accident, a severity risk rating is given, and immediate action is documented with any follow-up action(s) required, evidenced in twelve accident/incident forms reviewed (witnessed and unwitnessed falls, behaviours that challenge, pressure injury, absconding, choking event, skin tears). Data is analysed for each unit and results were discussed in the quality and staff meetings. Staff interviewed confirmed they are informed at handover of residents of concern. The system escalates alerts to senior team members depending on the risk level. A summary is provided against each clinical indicator data. Benchmarking occurs on a national level against other Arvida facilities and other aged care provider groups. Discussions with the village manager and clinical coordinators evidenced awareness of their requirement to notify relevant authorities in relation to essential notifications. There has been one HealthCERT notification related to a change in clinical coordinator/acting clinical manager and five Section 31 notifications completed to notify HealthCERT from April 2023 year to date and include one related to a missing resident; one police involvement related to unexpected death; one pressure injury; and two related to alleged assault. The Covid-19 outbreak in May 2023 and one Norovirus outbreak August/September 2023 was appropriately reported to Public Health.
Subsection 2.3: Service management The people: Skilled, caring health care and support workers listen to me, provide personalised care, and treat me as a whole person. Te Tiriti: The delivery of high-quality health care that is	FA	Human resources policies include documented rationale for determining staffing levels and skill mixes for safe service delivery. Sufficient staff are rostered on to manage the care requirements of the residents. The service has a total of 214 staff in various roles. Staffing rosters were sighted and there is staff on duty to match needs of different shifts. The

culturally responsive to the needs and aspirations of Māori is achieved through the use of health equity and quality improvement tools. As service providers: We ensure our day-to-day operation is managed to deliver effective person-centred and whānau-centred services.		acting clinical manager and senior clinical coordinator works 40 hours per week, Monday to Friday. In addition, there are two full time clinical coordinators sharing the oversight of the four households. The clinical coordinators share the weekends and on call after hours duties. The NP practice provides after hour support. The clinical coordinators (all RNs) are all rostered on as additional staff to the RNs and rostered in a manner that the weekend is covered with at least one clinical coordinator. The clinical coordinators are aware that extra staff can be called on for increased resident requirements. The service is divided across four households and two separate buildings. Nimon (23 beds) and the Goddard B wing (16 beds) were temporary closed at the time of the audit. There are at least one RN on in each building 24/7, supported by team leaders (senior medication competent wellness partners or enrolled nurses) and a full complement of wellness partners with at least seven wellness partners at night. There is at least one person on shift in each building with a first aid certificate. Interviews with staff, residents and family /whānau confirmed there are sufficient staff to meet the needs of residents. The staffing numbers has significantly improved since the previous audit and the staff interviewed stated minimal agency staff are used. The acting clinical manager confirmed successful recruitment strategies are in place. There is an annual education and training schedule that is implemented for 2023. External training opportunities for care staff include training through Te Whatu Ora Health New Zealand -Te Matau a Māui Hawkes Bay, and hospice. Arvida Mary Doyle supports all employees to transition through the New Zealand Qualification Authority (NZQA) Careerforce Certificate for Health and Wellbeing. There are 110 wellness partners employed. Forty-seven wellness partners have achieved level four certificate Health and Wellbeing. All staff are required to complete competency assessments as part of their orientation. There is an ongoing competency schedule in place. Registered nurses' complete competencies including restraint, medication competency (including controlled drug management, insulin administration and syringe driver training). Additional RN specific competencies include an interRAI assessment competency. All staff have completed restraint competencies.

		The previous audit finding related to staff competencies 2.3.3 has been addressed. Ten of eighteen RNs are interRAI trained. All RNs are encouraged to attend in-service training and completed critical thinking and problem solving, infection prevention and control, including Covid-19 preparedness, dementia, and delirium. There are 23 wellness partners allocated to the dementia unit; eight have competed the relevant required dementia standards and 15 are in progress of completing their dementia standards. All eight have completed the relevant education within the required 18-month period.
Subsection 2.4: Health care and support workers 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. 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. 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.	FA	Eight staff files reviewed had training, competencies and professional qualifications on file where required. There is an appraisal policy and an appraisal schedule. All staff that had been in employment for more than 12 months had an annual appraisal completed. The previous audit finding 2.4.5 related to the implementation of the appraisal schedule has now been addressed. A register of practising certificates is maintained for all health professionals. The service has an orientation programme in place that provides new staff with relevant information for safe work practice and includes buddying when first employed. Competencies are completed at orientation. The service demonstrates that the orientation programme supports RNs and caregivers to provide a culturally safe environment for Māori. Caregivers interviewed reported that the orientation process prepared new staff for their role and could be extended if required.
Subsection 3.2: My pathway to wellbeing 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. Te Tiriti: Service providers work in partnership with Māori and whānau, and support their aspirations, mana motuhake, and whānau rangatiratanga.	PA Moderate	Six electronic resident files were reviewed: two dementia resident files including one on long-term support chronic health contract (LTS-CHC); two rest home resident files and two dementia resident files. The registered nurses (RN) are responsible for all residents' assessments, care planning and evaluation of care. Care plans are based on data collected during the initial nursing assessments, which include dietary needs, pressure injury, falls risk, social history, and information from pre-entry assessments.

As service providers: We work in partnership with people and whānau to support wellbeing.		Initial assessments and long-term care plans were completed for residents within the required timeframes, detailing needs, and preferences. The service uses assessment tools that include consideration of residents' lived experiences, cultural needs, values, and beliefs. Each care plan was reflective of assessment outcomes, and individualised. InterRAI assessments had been completed for all residents. Assessment tools used included but not limited to falls, skin, pressure risk, nutrition, activities, mobility, and pain. The individualised long-term care plans (LTCP) were formulated with information gathered during the initial assessments and the interRAI assessment. All LTCPs and interRAI sampled (except for recent admission) had been completed within three weeks of the residents' admission to the facility. This is an improvement upon the previous audit, and the partial attainment relating to 3.2.1 has been satisfied. Documented interventions and early warning signs meet the residents' assessed needs; with the care plans detailing detailed interventions to provide guidance to care staff in the delivery of care. The activity assessments include a cultural assessment which gathers information about cultural needs, values, and beliefs. Information from these assessments is used to develop the resident's individual activity care plan. Interventions in the long-term care plans were comprehensive and resident focussed and provide detail to guide staff in the management of each resident`s care. Goals, interventions and evaluations of short-term needs such as weight loss, infections and wounds are integrated in the long-term care plans, and these were sighted for the files reviewed. Residents in the dementia units (Goddard and Ashcroft households) all have behaviour assessment and a behaviour plan with associated risks and supports needed and includes strategies for managing/diversion of behaviours. The long-term care plans; however, do not always include a 'rhythm of the day' that reflects a 24-hour reflection of close to normal routine for the resident to assist staff in management of the resident behaviours. Resident care is evaluated on each shift and reported at handover and in the progress notes. If any change is noted, it is reported to the RN; however, this has not always been completed for residents presenting with acute changes in health status. The partial attainment relating to 3.2.5 continues to remain ongoing. Long-term care plans are formally evaluated

		every six months in conjunction with the interRAI re-assessments and when there is a change in the resident's condition. Evaluations are documented by an RN and include the degree of achievement towards meeting desired goals and outcomes. Residents interviewed confirmed assessments are completed according to their needs and in the privacy of their bedrooms. There was evidence of family/whānau involvement in care planning and documented ongoing communication of health status updates. Family/whānau interviews and resident records evidenced that family/whānau are informed where there is a change in health status. The service has policies and procedures in place to support all residents to access services and information. The service supports and advocates for residents with disabilities to access relevant disability services. The initial medical assessment is undertaken by the nurse practitioner (NP) within the required timeframe following admission. Residents have ongoing reviews by the NP within required timeframes and when their health status changes. The NP visits the facility three times a week and as required. Documentation and records reviewed were current. The NP interviewed stated that there was good communication with the service and that they were informed of concerns in a timely manner. The NP provides on call services 24/7. There is access to a physiotherapist for two hours a week and continence specialist via referral as required. A podiatrist visits regularly and a dietitian, speech language therapist, hospice, wound care nurse specialist and medical specialists are available as required through the local Te Whatu Ora Health New Zealand - Te Matau a Māui Hawke's Bay. An adequate supply of wound care products were available at the facility. A review of the wound care plans evidenced wounds were assessed in a timely manner and reviewed at appropriate intervals. Photos were taken where this was required. Where wounds required additional specialist input, this was initiated, and a wound nurse specialist was consulted. At the time of the audit there were 24 active wounds from 18 residents, including one stage two pressure injury. The clinical progress notes are recorded and maintained on the electronic resident management system. Wellness partners document each shift in the progress notes Registered nurses document in the progress notes every 24hours for hospital level care and at least weekly for dementia and

		rest home level care. Monthly observations such as weight and blood pressure were completed and are up to date. A range of monitoring charts are available for the care staff to utilise on the electronic system. Staff interviews confirmed they are familiar with the needs of all residents in the facility and that they have access to the supplies and products they require to meet those needs. Staff receive handover at the beginning of their shift. Each event involving a resident reflected a clinical assessment and a timely follow up by a RN. Family/whānau are notified following incidents. Neurological observations are recorded following all un-witnessed falls. Opportunities to minimise future risks are identified by the clinical managers in consultation with the allied staff, RNs, and wellness partners.
Subsection 3.4: My medication The people: I receive my medication and blood products in a safe and timely manner. Te Tiriti: Service providers shall support and advocate for Māori to access appropriate medication and blood products. 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.	FA	There are policies available for safe medicine management that meet legislative requirements. All staff who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided as part of the competency process. Registered nurses have completed syringe driver training. Staff were observed to be safely administering medications. The registered nurses and medication competent wellness partners interviewed could describe their role regarding medication administration. The service currently uses robotics rolls for regular medication and blister packs for pro re nata (PRN) and short course. There is a clear process of ensuring all medications are checked on delivery against the medication chart and any discrepancies are fed back to the supplying pharmacy. Medications were appropriately stored in the facility medication rooms. The medication fridge and medication room temperatures are monitored daily, and the temperatures were within acceptable ranges. All eyedrops and creams have been dated on opening. This is an improvement upon the previous audit, and the partial attainment relating to 3.4.1 has been satisfied. All stored medications are checked monthly. Controlled drugs are stored safely, and review of the controlled drug register confirmed that stock check was completely weekly and additionally every Monday and Friday for the suspensions as a corrective from the last internal audit finding. Records indicate staff were signing appropriately for all entries, correct running totals noted and where discrepancies were identified incident forms were completed with appropriate follow-up put in place. This

		is an improvement upon the previous audit, and the partial attainment relating to 3.4.1 has been satisfied. Twelve electronic medication charts were reviewed. The medication charts reviewed identified that the nurse practitioner had reviewed all resident medication charts three-monthly, and each drug chart has a photo identification and allergy status identified. Effectiveness of Pro re nata (PRN) medication are recorded in the progress notes and electronic medication chart. At the time of the audit there was one resident self-administering insulin whenever they were out and about including being responsible for the electronic monitoring of the blood glucose levels. At all other times staff were responsible for the administration of the insulin and the rest of their medications. Self-administration competency has been completed and signed by the resident, general practitioner, and clinical coordinator. Safe storage of the resident medications is in line with policy as sighted on the day. The previous audit shortfall 3.4.6 related to safe self-administration has been addressed. No vaccines are kept on site and no standing orders are used.
Subsection 3.5: Nutrition to support wellbeing The people: Service providers meet my nutritional needs and consider my food preferences. Te Tiriti: Menu development respects and supports cultural beliefs, values, and protocols around food and access to traditional foods. As service providers: We ensure people's nutrition and hydration needs are met to promote and maintain their health and wellbeing.	FA	The four-week seasonal menu is reviewed by a registered Arvida dietitian and follows Arvida 'Eating Well' requirements. Food preferences and cultural preferences are encompassed into the menu. The kitchen receives resident dietary forms and is notified of any dietary changes for residents. Dislikes and special dietary requirements are accommodated, including food allergies. The kitchen manager interviewed reported they accommodate residents' requests. Nutritional snacks are available 24 hours a day. There is a verified food control plan expiring October 2024. The residents and family/whānau interviewed were complimentary regarding the standard of food provided and the varied options for the residents to choose from.
Subsection 3.6: Transition, transfer, and discharge The people: I work together with my service provider so they	FA	There were documented policies and procedures to ensure discharging or transferring residents have a documented transition, transfer, or discharge plan, which includes current needs and risk mitigation. Planned discharges

know what matters to me, and we can decide what best supports my wellbeing when I leave the service. Te Tiriti: Service providers advocate for Māori to ensure they and whānau receive the necessary support during their transition, transfer, and discharge. 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 coordinate a supported transition of care or support.		or transfers were coordinated in collaboration with the resident (where appropriate), family/whānau and other service providers to ensure continuity of care.
Subsection 4.1: The facility 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. Te Tiriti: The environment and setting are designed to be Māori-centred and culturally safe for Māori and whānau. 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.	PA Low	The buildings, plant, and equipment are fit for purpose at Mary Doyle and comply with legislation relevant to the health and disability services being provided. The current building warrants of fitness expires 24 October 2024 (main building) and 16 June 2024 (Bramlee household). At the time of the audit 23 beds in Nimon household were temporarily closed with the last resident having been re-homed in November 2023 and 16 dementia beds in Goddard household remain closed. There is an electronic maintenance request process for repairs. Equipment failure or issues are also recorded in the maintenance electronic log. This is checked daily and signed off when repairs have been completed. There is an annual maintenance plan that includes electrical testing and tagging, equipment checks, call bell checks, calibration of medical equipment and monthly testing of hot water temperatures. Essential contractors/tradespeople are available 24 hours a day as required. Hot water temperature recording reviewed did not always have corrective actions undertaken when outside of expected ranges.
Subsection 5.1: Governance The people: I trust the service provider shows competent leadership to manage my risk of infection and use antimicrobials appropriately. Te Tiriti: Monitoring of equity for Māori is an important component of IP and AMS programme governance. As service providers: Our governance is accountable for ensuring the IP and AMS needs of our service are being met,	FA	There is an Arvida strategic plan and Arvida Attitude of Living Well community business plan that demonstrate commitment to compliance to the infection control and AMS policies. The infection control committee, with support from the Arvida support office and infection control clinical nurse lead, provides clinical governance oversight on infection control and AMS matters at Arvida Mary Doyle. Key performance indicators in relation to IPC and AMS are monitored and benchmarked. Infection rates are presented and discussed at quality meetings, clinical and full staff

and we participate in national and regional IP and AMS programmes and respond to relevant issues of national and regional concern.		meetings. This information was displayed on staff noticeboards. The service had two outbreaks since the last audit. There were recorded outbreak management meetings with lessons learned and debrief documented following both outbreaks. The previous audit finding related to outbreak meetings 5.1.4 has been addressed.
Subsection 5.2: The infection prevention programme and implementation The people: I trust my provider is committed to implementing policies, systems, and processes to manage my risk of infection. 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. As service providers: We develop and implement an infection prevention programme that is appropriate to the needs, size, and scope of our services.	FA	A registered nurse oversees the infection control and prevention across the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, pandemic and outbreak management and action plan, responsibilities during construction/refurbishment, training, and education of staff. Policies and procedures are reviewed by Arvida Group support office in consultation with infection control coordinators. Policies are available to staff. The infection control programme links to the quality programme. The infection control policy states that the facility is committed to the ongoing education of staff and residents. Infection prevention and control is part of staff orientation and included in the annual training plan (Altura). There has been additional training and education around Covid-19, norovirus outbreak management and staff were informed of any changes by noticeboards, handovers, and emails. Staff completed hand hygiene and personal protective equipment competencies.
Subsection 5.4: Surveillance of health care-associated infection (HAI) The people: My health and progress are monitored as part of the surveillance programme. Te Tiriti: Surveillance is culturally safe and monitored by ethnicity. 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	FA	Surveillance of healthcare-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. Infection surveillance is an integral part of the infection control programme and is described in the infection control manual. 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 risk management system. Surveillance of all infections (including organisms) is entered onto a monthly infection summary. This data is monitored and analysed for trends, monthly and annually. Arvida benchmark infection data against other aged care facilities.

programme, and with an equity focus.		There was evidence that results of the surveillance data are shared with staff; there were no data on the noticeboards and meeting minutes. Staff interviewed confirm they are informed of infection rates at handover and specifically individual residents of concern. All infections are collated, analysed (including ethnicity) and summaries provided. Where there are significant incidents related to infection and AMS, these are reported to the Arvida senior team and the Board as soon as possible. Since the previous audit, there was a Covid-19 outbreak in May 2023 and one Norovirus outbreak August/September 2023. Both outbreaks were appropriately reported to Public Health and managed effectively with support and advice from Te Whatu Ora –Te Matau a Māui Hawkes Bay, Arvida infection control clinical nurse lead and Public Health.
Subsection 5.5: Environment The people: I trust health care and support workers to maintain a hygienic environment. My feedback is sought on cleanliness within the environment. 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. As service providers: We deliver services in a clean, hygienic environment that facilitates the prevention of infection and transmission of antimicrobialresistant organisms.	FA	The facility has processes in place to manage the resident's clothing and personal items. Laundry/household staff have completed training related to their roles. Wellness partners completed infection control training as part of their orientation and annually (last completed in September 2023). Infection control education includes the handling of waste and the management of cleaning and laundry. There are documented processes for the transporting/moving of dirty linen in the facility. As observed on the days of the audit, the procedures were followed. Wellness partners were observed to have laundry trolleys readily available outside rooms where they provide cares when transporting dirty laundry. Wellness partners interviewed evidenced a good understanding of laundry practices. Bimonthly laundry audits, infection control to practice audits completed evidence full compliance. The infection control coordinator (RN) interviewed stated they provide oversight over the implementation of the laundry processes. The previous audit finding related to laundry practices 5.5.4 has been addressed.
Subsection 6.1: A process of restraint The people: I trust the service provider is committed to improving policies, systems, and processes to ensure I am	FA	Arvida Mary Doyle is committed to providing services to residents without the use of restraint. An interview with the restraint coordinator described the organisation's commitment to restraint minimisation and

free from restrictions. Te Tiriti: Service providers work in partnership with Māori to ensure services are mana enhancing and use least restrictive practices. As service providers: We demonstrate the rationale for the use of restraint in the context of aiming for elimination.		implementation across the organisation. The board is committed to the elimination of restraint use and this is actively monitored by the Wellness and Care team. This is achieved using proactive de-escalation strategies. The designated restraint coordinator is a registered nurse, supported by the clinical manager. At the time of the audit there no residents using restraints. Restraint documentation processes sighted are robust to include assessments, consent, monitoring, and evaluation processes to minimise associated risks. When in use, quality review of restraint use occurs monthly and is benchmarked. The use of restraint is reported in the quality management, registered nurse, and staff meetings. Training for all staff occurs at orientation and annually as sighted in the training records. Staff have completed online training related to restraint

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)
Criterion 3.2.3 Fundamental to the development of a care or support plan shall be that: (a) Informed choice is an underpinning principle; (b) A suitably qualified, skilled, and experienced health care or support worker undertakes the development of the care or support plan; (c) Comprehensive assessment includes consideration of people’s lived experience; (d) Cultural needs, values, and beliefs are considered; (e) Cultural assessments	PA Low	The registered nurses are responsible for the development of the care plan. Assessment tools including cultural assessments were completed to identify key risk areas. Alerts are indicated on the resident care plan and include (but not limited to) high falls risk, weight loss, wandering, choking and pressure injury risks. The registered nurses interviewed understand their responsibility in relation to assessment and care planning. There are comprehensive policies in place related to assessment and care planning; however, the two care plans for residents in the dementia household did not provide interventions of close to normal routine for the residents over a 24-hour period to assist caregivers in the management of behaviours.	Two of two care plans reviewed for residents in the dementia household did not include a 24-hour reflection of close to normal routine for the resident with detailed interventions to assist wellness partners in strategies for distraction, de-escalation, and management of challenging resident behaviours.	Ensure that care plans for residents in the dementia unit provide a 24-hour reflection of close to normal routine for the resident with detailed interventions to assist wellness partners in strategies for distraction, de-escalation, and management of challenging resident behaviours. 90 days

are completed by culturally competent workers and are accessible in all settings and circumstances. This includes traditional healing practitioners as well as rākau rongoā, mirimiri, and karakia; (f) Strengths, goals, and aspirations are described and align with people's values and beliefs. The support required to achieve these is clearly documented and communicated; (g) Early warning signs and risks that may adversely affect a person's wellbeing are recorded, with a focus on prevention or escalation for appropriate intervention; (h) People's care or support plan identifies wider service integration as required.		Wellness partners are knowledgeable about the care needs of the residents and the families/whanau interviewed were complimentary of the care provided. Progress notes and monitoring records evidence care delivery to the residents reflective of their needs as described by staff during interviews and confirmed by residents, family/whānau interviewed. The findings related to care planning relates to documentation only.		
Criterion 3.2.5 Planned review of a person's care or support plan shall: (a) Be undertaken at defined intervals in collaboration with the person and whānau, together with wider service providers; (b) Include the use of a range of outcome	PA Moderate	All resident files reviewed included a long-term care plan and the provider meets evaluation timeframes according to aged resident care contract held. Registered nurse oversight is rostered for the rest home residents and registered nurses have documented a regular review of care. If any change is noted, it is reported to the registered nurse; however, this was not completed for one rest home resident who returned from social leave and family notified staff of a fall while at home with	There was no comprehensive assessment completed by the registered nurse for a rest home resident who returned from social leave and reported by the family to have had a fall at home sustaining a skin tear and presenting with confusion and disorientation.	Ensure registered nurse assessment is completed for residents with acute changes in health status. 30 days

measurements; (c) Record the degree of achievement against the person's agreed goals and aspiration as well as whānau goals and aspirations; (d) Identify changes to the person's care or support plan, which are agreed 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.		then presentation of confusion and disorientation. The resident was later transferred to hospital the following day following readings of high blood glucose recordings.		
Criterion 4.1.1 Buildings, plant, and equipment shall be fit for purpose, and comply with legislation relevant to the health and disability service being provided. The environment is inclusive of peoples' cultures and supports cultural practices.	PA Low	There is a maintenance request process for repair and maintenance requests. This is checked daily and signed off when repairs have been completed. There is evidence of an annual preventative maintenance plan initiated and implemented for the service. Processes around the reactive and planned maintenance were confirmed by interview with the grounds and maintenance supervisor and village manager. Hot water temperatures are checked by the maintenance person and recorded on the temperature monitoring record. However,	There is no evidence of corrective actions being completed for hot water temperature monitoring results that are out of range of the acceptable limits.	Ensure corrective actions are put in place for hot water temperatures out of expected range. 90 days

		where the temperature recordings were out of expected range (for July August September in Ashcroft household), there is no evidence of corrective action being put in place at the time. Essential contractors/tradespeople are available 24/7 as required		

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

No data to display

End of the report.