

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

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## Introduction

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

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

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

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

The specifics of this audit included:

<b>Legal entity:</b>	Molly Ryan Lifecare (2007) Limited	
<b>Premises audited:</b>	Molly Ryan Lifecare and Retirement Village	
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)	
<b>Dates of audit:</b>	Start date: 7 February 2018	End date: 8 February 2018
<b>Proposed changes to current services (if any):</b>	No	
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	36	

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# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

## General overview of the audit

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

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

An experienced village manager manages the service. She is supported by an experienced clinical manager. Family and residents interviewed all spoke positively about the care and support provided.

There are systems, processes, policies and procedures that are structured to provide appropriate care for residents. Implementation is being supported through the organisations quality and risk management programme. An induction and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place.

A continued improvement rating has been awarded around restraint minimisation.

## Consumer rights

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

Standards applicable to this service fully attained.

Staff at Molly Ryan Lifecare strive to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner's Code of Consumers' Rights (the Code). Residents' cultural needs are met. Policies are implemented to support residents' rights, communication and complaints management. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns have been managed and a complaints register is maintained.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.

Standards applicable to this service fully attained.

Molly Ryan Lifecare has a current strategic plan and a quality assurance and risk management programme that outlines objectives for the next year. The quality process being implemented includes regularly reviewed policies. Aspects of quality information are reported to two-monthly combined staff and monthly quality meetings. There is an annual internal audit calendar schedule. Residents and relatives are provided the opportunity to feedback on service delivery issues at bi-monthly resident meetings and via satisfaction surveys. There is a reporting process being used to record and manage resident incidents. Incidents are collated monthly and reported to facility meetings. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The in-service education programme for 2017 has been completed and the plan for 2018 is being implemented. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.

Standards applicable to this service fully attained.

There is an admission package available prior to or on entry to the service. The registered nurses are responsible for each stage of service provision. A registered nurse assesses, plans and reviews residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed demonstrated service integration and were evaluated at least six-monthly. InterRAI assessments are utilised. Resident files included medical notes by the general practitioner and visiting allied health professionals. Medication policies reflect legislative requirements and guidelines. Registered nurses, enrolled nurses and senior caregivers responsible for administration of medicines complete education and medication competencies.

The medicine charts were reviewed at least three-monthly by the general practitioner. An integrated activity programme is implemented for residents at rest home and hospital level of care. The programme includes community visitors and outings, entertainment and activities that meet the individual physical, cultural and cognitive abilities and preferences for each resident group. Residents and families report satisfaction with the activities programme. Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on-site. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.

Standards applicable to this service fully attained.

Molly Ryan Lifecare has a current building warrant of fitness. There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Chemicals are stored safely throughout the facility. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. Resident bedrooms are personalised with ensembles. Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. Documented systems are in place for essential, emergency and security services. All registered nurses hold a current first aid certificate.

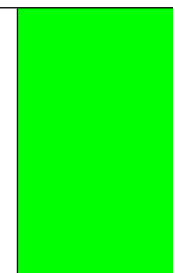
## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.	All standards applicable to this service fully attained with some standards exceeded.
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Molly Ryan Lifecare has restraint minimisation and safe practice policies and procedures in place. Staff receive training around restraint minimisation and the management of challenging behaviour. On the days of the audit there were no residents with restraints or using an enabler. The service has worked towards a restraint-free environment. The clinical manager is the designated restraint coordinator.

## Infection prevention and control

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



Standards applicable to this service fully attained.

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is reviewed annually and meets the needs of the service. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.



## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	1	45	0	0	0	0	0
<b>Criteria</b>	1	93	0	0	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation.	FA	The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. Discussions with five care staff (three caregivers, one registered nurse (RN) and one diversional therapist) confirm their familiarity with the Code. Interviews with four residents (three rest home and one hospital) and three families (two rest home and one hospital) confirm the services being provided are in line with the Code. The Code is discussed at resident, staff and quality meetings. Staff receive training on the Code, last occurring in April 2017.
Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Informed consent processes were discussed with residents (as appropriate) and families on admission. Written general and specific consents were evident in the six resident files reviewed (four rest home including one resident in the studio apartments and two hospital level of care residents). Caregivers and RNs interviewed confirm consent is obtained when delivering cares. Advance directives identified the resident resuscitation status. Advance directives had been appropriately signed by the resident and general practitioner (GP). The service acknowledges the resident is for resuscitation in the absence of a signed directive by the resident. Copies of EPOA are contained within the resident file. Discussion with family members identified that the service actively involves them in decisions that affect their relative's lives. Six signed admission agreements were sighted for the resident files reviewed.

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>A policy describes access to advocacy services. Staff receive training on advocacy, last occurring in October 2017. Information about accessing advocacy services information is available in the entrance foyer. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Advocate support is available if requested. Interviews with staff and residents informed they are aware of advocacy and how to access an advocate.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are encouraged to be involved in community activities and maintain family and friends' networks. On interview, staff stated that residents are encouraged to build and maintain relationships. All residents and relatives interviewed confirmed that relative/family visiting could occur at any time.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a complaints policy and procedure in place and residents and their family/whānau are provided with information on the complaints process on admission via the information pack. Complaint forms are available at each entrance of the services. Staff are aware of the complaints process and to whom they should direct complaints. A complaints register is available. One complaint has been received at Molly Ryan Lifecare since the last audit. The complaint reviewed had been managed appropriately with acknowledgement, investigations and responses recorded. Residents and family members advised that they are aware of the complaints procedure and how to access forms.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>There are posters of the Code on display throughout the facility and leaflets are available in the foyer of the facility. The service is able to provide information in different languages and/or in large print if requested. Information is also given to next of kin or enduring power of attorney (EPOA) to read with the resident and discuss. On entry to the service, the village manager or clinical manager discusses the information pack with the resident and the family/whānau. The information pack includes a copy of the Code.</p>
<p>Standard 1.1.3: Independence, Personal</p>	FA	<p>The service has policies that align with the requirements of the Privacy Act and Health Information Privacy Code. Staff were observed respecting resident's privacy and could describe how they manage maintaining</p>

<p>Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>		<p>privacy and respect of personal property. There is a policy that describes spiritual care. Church services are conducted regularly. Residents interviewed indicated that resident's spiritual needs are being met when required.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The service has established cultural policies to help meet the cultural needs of its residents. There is a Māori health plan. There was one resident that identified as Māori at the time of the audit. The service has established links with the local iwi. Cultural and spiritual practice is supported and identified needs are incorporated into the care planning process. Discussions with staff confirm that they are aware of the need to respond to cultural differences.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The service has established cultural policies aimed at helping meet the cultural needs of its residents. Residents interviewed reported that they were satisfied that their cultural and individual values were being met. Information gathered during assessment including resident's cultural beliefs and values, is used to develop a care plan, which the resident (if appropriate) and/or their family/whānau are asked to consult on. Staff receive training on cultural awareness, last occurring in January 2018.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>The facility has a staff code of conduct which states there will be zero tolerance against any discrimination occurring. The abuse and neglect processes cover harassment and exploitation. All residents interviewed reported that the staff respected them. Job descriptions include responsibilities of the position, ethics, advocacy and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct.</p>

<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service has policies to guide practice that align with the Health and Disability Services Standards, for residents with aged care needs. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. Residents and families interviewed spoke positively about the care and support provided. Staff interviewed had a sound understanding of principles of aged care and stated that they feel supported by the management team.</p> <p>Arvida is operationalising their vision 'to transform the ageing experience' within the care communities through the introduction of the "Wellness model". The Wellness model focuses on the relationship between the care team and the resident as partners in the pursuit of a rich and meaningful life. Molly Ryan Lifecare introduced this model in late 2107. The emphasis is on supporting each resident to live well and be actively engaged in their life the way they want it to be. Small groups of residents are supported within the care communities by decentralised self-led teams of employees that together create home, nurture relationships, determine their own lives and build community. Residents are encouraged and supported to create a comfortable living space suited to their particular needs and personal tastes.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Residents interviewed stated they were welcomed on entry and given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Ten incident/accidents (six hospital and four rest home) forms reviewed for January 2018 had documented evidence of family notification or noted if family did not wish to be informed. Three relatives interviewed confirmed that they are notified of any changes in their family member's health status. Four residents interviewed stated that they were welcomed on entry and were given time and explanation about the services and procedures. Interpreter services are available as required.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Molly Ryan Lifecare is part of the Arvida Group. Molly Ryan Lifecare is certified to provide rest home and hospital (geriatric and medical) for up to 61 residents across the rest home and studio apartments. There are 33 care home beds which are all dual-purpose. There are 28 studio apartments. Twenty-three apartments are certified for rest home or retirement village residents and five are certified for either rest home or hospital residents. Occupancy on the day of audit was 36 residents (20 rest home and 13 hospital residents, including one resident on an ACC funded contract in the care home and three rest home residents in the studio apartment area). There were no residents on respite.</p> <p>There is a village manager who has been in the role since July 2017. She is supported by an experienced clinical manager who has been in the position for one month, and in the aged care industry for over seventeen years. The village manager and clinical manager are supported by the general manager</p>

		<p>operations, general manager wellness and a national quality manager (who was present on the days of the audit).</p> <p>The village manager reports to the general manager operations on a variety of operational issues and provides a monthly report. Arvida has an overall business/strategic plan. The organisation has a philosophy of care, which includes a mission statement. Molly Ryan Lifecare has a business plan for 2018 and a quality and risk management programme. The business plan identifies the future provision of hospital and medical services.</p> <p>The village manager has completed in excess of eight hours of professional development in the past 12 months.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>In the absence of the village manager, the clinical manager is in charge. Support is provided by the general manager operations, the general manager wellness and care and the care staff.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>There is a 2018 business/strategic plan that includes quality goals and risk management plans for Molly Ryan Lifecare. Interviews with staff confirmed that there is discussion about quality data at various staff meetings. The village manager is responsible for providing oversight of the quality programme on site, which is also monitored at organisational level. The quality and risk management programme is designed to monitor contractual and standards compliance. The site-specific service's policies are being transitioned over to the Arvida Group policies, which will be reviewed at least every two years across the group. Head office sends new/updated policies. Data is collected in relation to a variety of quality activities and an internal audit schedule has been completed. Areas of non-compliance identified through quality activities are actioned for improvement. The service has a health and safety management system that is regularly reviewed. Restraint and enabler use (which have not been used for over 9 months) is reviewed within the quality and clinical staff meetings. Data is collected in relation to a variety of quality activities and an internal audit schedule has been completed. Areas of non-compliance identified through quality activities are actioned for improvement.</p> <p>All staff interviewed could describe the quality programme corrective action process. Health and safety</p>

		goals are established and regularly reviewed. Risk management, hazard control and emergency policies and procedures are being implemented and are monitored by the Health and Safety Committee. The Health and Safety Committee has been recently changed to have more representative membership; six representatives have received specific health and safety training in their role. Hazard identification forms and a hazard register are in place. The overall service result for the resident/relative satisfaction survey completed in March 2017 was at 86%. Residents/relatives are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families. Resident/family meetings occur bi-monthly and resident and families interviewed confirmed this. Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>There is an accidents and incidents reporting policy. The clinical manager investigates accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at staff meetings including actions to minimise recurrence. An RN conducts clinical follow-up of residents. Ten incident forms reviewed demonstrated that appropriate clinical follow-up and investigation occurred following incidents. Neurological observation forms were documented and completed for any unwitnessed falls. Discussions with the village manager and clinical manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. The Ministry of Health have been notified of the recent change in the clinical manager.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are human resource management policies in place. This includes that the recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. Eight staff files were reviewed (one clinical manager, two RNs, three caregivers, one diversional therapist and one kitchen manager). There is evidence that reference checks were completed before employment was offered. Annual staff appraisals were evident in all staff files reviewed. A copy of practising certificates is kept. The service has an orientation programme in place that provides new staff with relevant information for safe work practice.</p> <p>Completed orientation is on files and staff described the orientation programme. The in-service education programme for 2017 has been completed and the plan for 2018 is being implemented. The village manager, clinical manager and RNs are able to attend external training, including sessions provided by the local District Health Board (DHB). Discussions with the caregivers and the RNs confirmed that ongoing training is encouraged and supported by the service. Eight hours of staff development or in-service education has been provided annually. There are ten RNs and three have completed interRAI training.</p>

<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>Molly Ryan Lifecare policy includes staff rationale and skill mix. Sufficient staff are rostered on to manage the care requirements of the residents. The service has a total of 60 staff in various roles. Staffing rosters were sighted and there is staff on duty to match needs of different shifts. The village manager and clinical manager work 40 hours per week from Monday to Friday and are available on call after hours. In addition to the village manager and clinical manager, there is at least one RN on at any one time. The RN on each shift is aware that extra staff can be called on for increased resident requirements. Interviews with staff, residents and family members confirm there are sufficient staff to meet the needs of residents.</p> <p>At the time of the audit, there were 20 rest home residents and 13 hospital residents in the care home. There is one RN on the morning and afternoon shifts, and one on night duty. The RNs are supported by five caregivers rostered on the morning, four caregivers on the afternoon shift and one caregiver on night duty. This roster is adjusted as hospital residents are admitted with general ratios of 1:5 for hospital level residents and 1:10 for rest home residents or a combination as resident needs dictate. There are three rest home residents in the studio apartments and there is one caregiver servicing them on the morning shift. The caregivers in the care home supervise the rest home level care residents in the studio apartments on the afternoon and night shifts.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are being transitioned to an electronic resident management system and password protected from unauthorised access. Paper records are secured in the locked nurses' stations. Other residents or members of the public cannot view sensitive resident information.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Residents' entry into the service is facilitated in a competent, equitable, timely and respectful manner. Admission information packs on the services and levels of care are provided for families and residents prior to admission or on entry to the service. All admission agreements reviewed align with all contractual requirements. Exclusions from the service are included in the admission agreement.</p>



<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Planned exits, discharges or transfers were coordinated in collaboration with the resident and family to ensure continuity of care. There were documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The residents and their families were involved for all exit or discharges to and from the service.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Clinical staff who administer medications (RNs, enrolled nurses and senior caregivers) have been assessed for competency on an annual basis. Annual education around safe medication administration has been provided by the pharmacist. Registered nurses complete syringe driver training. Monthly delivery of medication robotic rolls is checked against the pharmacy generated medication charts by the RN on duty, as evidence on the signing sheet. Medication fridges are checked daily and are maintained within the acceptable temperature range. All eye drops, and ointments were dated on opening. There were no residents self-medicating. Fourteen medication charts (eight rest home and six hospital) reviewed had photo identification, allergy status and had been reviewed by the GP at least three-monthly.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>All meals are prepared and cooked on-site by a qualified chef assisted by a kitchenhand. Food services staff have attended food safety training. The eight-weekly seasonal menu has been reviewed by the company dietitian. There are two choices of main meals and options for the evening meal. Cultural preferences and special diets are met, including gluten free, vegetarian, pureed meals and diabetic desserts. Resident dislikes are known and accommodated. The chef receives a resident dietary profile for new and respite care residents and is notified of any dietary changes. Meals are transported in foil covered pots to the dining room bain marie.</p> <p>Meals are served and plated by the chef as observed on the day of audit. Fridge and freezer temperatures are taken and recorded daily. End cooked food temperatures are recorded daily. Perishable foods sighted in the fridges were dated. All dry goods were labelled with expiry dates. The dishwasher is checked monthly by the chemical supplier. Staff have received training in chemical safety. A cleaning schedule is maintained. Resident meetings and surveys, along with direct input from residents, provide resident feedback on the meals and food services generally. Residents and family members interviewed were satisfied with the meals and confirmed alternative food choices were offered for dislikes.</p>
<p>Standard 1.3.2: Declining</p>	FA	<p>There is an admission information policy. The reasons for declining entry would be if the service is unable to provide the level of care required or there are no beds available. Management communicate directly with</p>

Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.		the referring agencies and family/whānau as appropriate if entry was declined.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	The RN completes an initial assessment on admission including risk assessment tools. A long-term care plan is completed within 21 days of admission and thereafter six-monthly, or earlier due to health changes. All six files reviewed identified interRAI assessment notes and summaries were available. Resident needs and supports are identified through available information such as discharge summaries, medical notes and in consultation with significant others. The outcomes of assessment tools are linked to the long-term care plan. The resident needs, goals and supports are documented in the long-term care plans.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Resident care plans reviewed (paper-based and electronic) were resident focused and individualised. Support needs as assessed were included in the long-term care plans reviewed. Short-term care plans are used for changes to health status and are generated on the electronic system. Care plans evidenced resident (as appropriate) and family/whānau involvement in the care plan process. Relatives interviewed confirmed they were involved in the care planning process. There was evidence of allied health care professionals involved in the care of the resident including the GP, physiotherapist, podiatrist, hospice and dietitian.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	When a resident's condition alters, the RN initiates a review and if required, GP, nurse specialist consultation. There is documented evidence on the family/whānau contact form (or in the electronic system) in each resident file that evidences family were notified of any changes to their relative's health including (but not limited to): accident/incidents, behaviours, infections, health professional visits, referrals and changes in medications. Adequate dressing supplies were sighted in treatment room. Wound management policies and procedures are in place.  Wound assessment and treatment forms, ongoing evaluation form and evaluation notes were in place for four residents with wounds (two chronic). There were no current pressure injuries. The service can access the DHB wound nurse specialist if required. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. Residents are

		<p>weighed monthly or more frequently if weight is of concern. Nutritional requirements and assessments are completed on admission identifying resident nutritional status and preferences.</p> <p>Monitoring occurs for weight, blood pressure, blood sugar levels, pain, neurological observations, food and fluid charts. The RN monitors and reviews the monitoring forms daily on the electronic system. Care staff report any changes to the RN. The RNs review the electronic daily work logs which includes such cares as position changes, food and fluid intake and toileting.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The service employs a qualified diversional therapist who has been in the role seven years and is on duty Monday to Friday 9am to 4pm. The integrated programme offers choice and variety of activities for residents to attend including, crafts, board games, card games, newspaper reading, exercises including a “walking train: indoors and outdoors” and target bowls. A volunteer is involved in the programme assisting with newspaper reading, calling housie/bingo and spending one-on-one time with hospital residents. Resident led groups include the residents’ choir and knitting group. There are weekly outings for rest home residents and a mobility van is hired monthly for hospital residents. There are regular outings for drives and attending community events and inter-home visits.</p> <p>Community visitors to the facility include entertainers, canine therapy, pre-school dancers and church visitors for regular interdenominational and Catholic church services. Rest home residents in the serviced apartments are invited to participate in the activities in the care centre. A resident profile “About Me” is completed on admission. Individual leisure activity plans were seen in all resident files reviewed. The DT is involved in the six-monthly multidisciplinary review. The service receives feedback and suggestions for the programme through resident meetings and surveys. Residents interviewed were happy with the activity programme.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>All initial care plans for long-term residents were evaluated by the RN within three weeks of admission. Long-term care plans have been evaluated by the multidisciplinary team at least six-monthly or earlier for any health changes. Written evaluations (currently all paper-based) identified if the resident/relative desired goals had been met or unmet. Family are invited to attend the MDT review and informed of any changes if unable to attend. The GP reviews the residents at least three-monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the electronic progress notes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And</p>	FA	<p>Referral to other health and disability services is evident in the resident files sampled. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There are documented policies and procedures in relation to exit, transfer or transition of residents. The</p>

External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.		residents and the families are kept informed of the referrals made by the service.
Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Material safety data sheets and product use charts are readily accessible for staff. Chemicals are stored safely throughout the facility. All chemical bottles have manufactures labels. Personal protective clothing is available for staff and seen to be worn by staff when carrying out their duties on the day of audit. Staff have completed chemical safety training provided by the chemical supplier.
Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	<p>The building has a current building warrant of fitness that expires 23 January 2019. There is a lift and stair access between the downstairs and upstairs resident rooms. The service employs a full-time maintenance person to carry out daily maintenance requests and planned maintenance as scheduled including hot water temperature monitoring. The maintenance person holds a site safety certificate. Essential contractors are available 24 hours. Annual calibration and functional checks of medical equipment including hoists is completed by an external contractor. Electrical testing and tagging is completed annually by an external contractor.</p> <p>There have been environmental improvements including refurbishment of resident rooms as they become vacant, new carpet and improved lighting in the main corridors, new outdoor deck, outdoor carpet on all ramps and purpose-built scooter shed. The facility has wide corridors and sufficient space for residents to safely mobilise using mobility aids or for the use of hospital recliners on wheels. There is to safe access the outdoor areas and internal courtyards. Seating and shade is provided. The caregivers and RNs interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans.</p>
Standard 1.4.3: Toilet,	FA	All resident rooms have ensuites. Toilets and shower facilities are of an appropriate size and design to meet

<p>Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>		<p>the needs of the residents. There are communal toilets located near communal areas. Residents interviewed confirm care staff respect the resident's privacy when attending to their personal cares.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All rooms are single. There is adequate room to safely manoeuvre mobility aids and transferring equipment such as hoists in the resident bedrooms within the care facility. Residents and families are encouraged to personalize bed rooms. A tour of the facility evidenced personalised rooms including the residents own furnishing and adornments. Studio apartments are spacious with ensuites.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>The care centre has a large main lounge area where most activities take place. There is a library room with access to an outdoor deck. The separate dining room is spacious. There are several seating alcoves within the facility. All communal areas are accessible to residents. Care staff assist or transfer residents to communal areas for dining and activities as required.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry</p>	FA	<p>There are policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. There are dedicated laundry and cleaners on duty seven days a week. The laundry and cleaning staff have completed chemical safety training and infection control education. The laundry has a defined clean/dirty area. The cleaner's trolleys are stored in a locked area when not in use. Staff were observed to be wearing appropriate personal protective clothing. Internal audits monitor the effectiveness of the cleaning and laundry processes. The chemical supplier conducts quality checks on the effectiveness of washing and</p>

services appropriate to the setting in which the service is being provided.		cleaning processes.
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>There are emergency and disaster management plans in place to ensure health, civil defence and other emergencies are included. There is a first aider on each shift. Emergency/disaster training last occurred in November 2017. Six-monthly fire evacuation practice documentation was sighted, with the last fire evacuation drill occurring on 15 November 2017. A contracted service provides checking of all facility equipment including fire equipment. Fire training and security situations are part of orientation of new staff and include competency assessments. Emergency equipment is available at the facility. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas cooking. Short-term backup power for emergency lighting is in place. All RNs hold a current first aid certificate. There are call bells in the residents' rooms and lounge/dining room areas. Residents were observed to have their call bells in close proximity.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>Residents were provided with adequate natural light and safe ventilation. Resident rooms are heated with radiator heating which can be individually thermostat controlled. There are efficient gas fires in the dining room and lounge.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The clinical manager is the infection prevention and control officer who has been in the role since January 2018. She has a job description that outlines the responsibility of the role. The infection prevention and control officer is supported by the Infection Control Committee who meet monthly and report to staff and management including head office. The infection control programme has been reviewed annually at the head office by the general manager wellness and is due again February 2018. Visitors are asked not to visit if they are unwell. Hand sanitizers were appropriately placed throughout the facility. Residents are offered the annual influenza vaccine.</p>

<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The infection prevention and control officer is new to the role and is scheduled to attend education in 2018. The Infection Control Committee are representatives from each area. Relevant personnel are invited to committee meetings as applicable. Management for the village and care centre also attend. Two enrolled nurses on the committee have attended external infection control education provided by an infection control consultant. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The infection prevention and control officer and Infection Control Committee have good support from the Arvida Group head office, the infection control nurse specialist at the DHB, external consultants, laboratory technician and GPs.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>There are Arvida Group infection control policies and procedures that are appropriate for the size and complexity of the service. The infection control manual outlines a range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred annually. Hand hygiene audits have been completed January 2018. All staff complete infection control orientation and questionnaires on employment. Information is provided to residents that is appropriate to their needs and this is documented in clinical records and resident meetings (as applicable).</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is</p>	FA	<p>Infection surveillance is an integral part of the infection control programme and is described in the Arvida Group infection control manual. Monthly infection data is collected for all infections based on standard</p>

carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.		definition of signs and symptoms of infections. Short-term care plans are used for infections. Surveillance of all infections is entered into the monthly online infection control register. This data is monitored and evaluated monthly, six-monthly and annually. Trends and analysis of infections and corrective actions are discussed at quality and Infection Control Committee meetings. Meeting minutes and graph are available to all staff. Benchmarking occurs within the Arvida Group. There has been one respiratory outbreak in July 2017. Relevant authorities were notified.
Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised.	FA	The service has documented systems in place to ensure the use of restraint is actively minimised. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. In mid-2017 the service has actively worked to minimise restraint use and maintain a restraint free environment. Although only, 10% of resident were using equipment deemed as restraint, alternatives were actively sought, Since June 2017, the service has not used restraint and has actively used alternatives to reduce the need for restraint and this has been maintained. At the time of the audit there were no residents with restraints or using an enabler. The no -restraint commitment is overseen by a restraint coordinator (clinical manager). Staff education on alternatives to restraint and management of challenging behaviour has been provided in September 2017.
Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint.	CI	The clinical manager is the restraint coordinator and reports to the quality team on a regular basis. The service has actively worked to promote and retain a restraint free environment and have achieved this since June 2017. The organisation also supports, and reviews restraint use across all its sites to minimise restraint.



## Specific results for criterion where corrective actions are required

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

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

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

No data to display
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 2.2.5.1 Services conduct comprehensive reviews regularly, of all restraint practice in order to determine: (a) The extent of restraint use and any trends; (b) The organisation's progress in reducing restraint; (c) Adverse outcomes; (d) Service provider compliance with policies and procedures; (e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice; (f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation; (g) Whether changes to policy, procedures, or guidelines are required; and (h) Whether there are additional education or training needs or changes required to existing education.	CI	Although there was less than 10% of residents using restraints, as a facility it was decided that a restraint free environment was the goal. This was achieved in June 2017, and has been maintained since then, by using alternatives to restraint	The clinical manager is the restraint coordinator and reports to the quality team on a regular basis. The service has actively worked to promote and retain a restraint free environment and have achieved this since June 2017. This approach has been supported by management with investment in alternatives such as sensor mats, low beds, landing mats and perimeter mattresses. Family/whanau have been actively involved in seeking alternatives options to ensure resident wellbeing and safety. The facility has remained restraint free for over nine months.

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End of the report.