

# Age Care Central Limited - Maryann Rest Home and Hospital

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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 The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

<b>Legal entity:</b>	Age Care Central Limited
<b>Premises audited:</b>	Maryann Rest Home and Hospital
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 10 March 2020 End date: 11 March 2020
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	46

# 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

Maryann Rest Home and Hospital is certified to provide residential care for up to 48 residents. The facility is operated by Agecare Central Limited and is managed by a chief executive. Residents and families spoke positively about the care provided.

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

Continuous improvement ratings have been awarded relating to the reduction of medication use and improved assessments by registered nurses resulting in reduced acute nurse practitioner visits and admissions to the local DHB hospital.

There are no areas requiring improvement from this audit.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents of Maryann Rest Home and Hospital. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

Services are provided that respect the choices, personal privacy, independence, individual needs and dignity of residents and staff were noted to be interacting with residents in a respectful manner.

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


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

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

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

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

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Maryann Rest Home and Hospital is governed by a board of trustees who are responsible for the service provided. The business plan is currently under review. Quality and risk management systems are fully implemented at Maryann Rest Home and Hospital

and include a mission statement, philosophy and goals. Systems are in place for monitoring the service, including regular reporting by the chief executive and the senior leadership team to the board.

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

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

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

The documented rationale for determining staffing levels and skill mixes is based on best practice. Registered nurses are always rostered on duty. The senior leadership team are on call after hours.

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

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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The organisation works closely with the local Needs Assessment and Service Co-ordination Service, to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, relevant information is provided to the potential resident/family to facilitate the admission.

Residents' needs are assessed by the multidisciplinary team on admission within the required timeframes. Shift handovers and electronically generated care reports guide continuity of care.

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

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

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

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


## Safe and appropriate environment

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

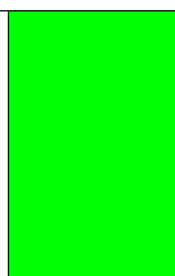
Residents' bedrooms provide single accommodation with adequate personal space provided. Lounges, dining areas and alcoves are available. External areas for sitting and shading are provided. An appropriate call bell system is available and security and emergency systems are in place.

## 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.		Standards applicable to this service fully attained.
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The service has clear policies and procedures that meet the requirements of the restraint minimisation and safe practice standard. There were residents using restraints and enablers at the time of audit.

## 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.
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The infection prevention and control programme, led by an experienced and appropriately trained infection control co-ordinator, aims to prevent and manage infections. Specialist infection prevention and control advice is accessed from the Taranaki District Health Board. The programme is reviewed annually.

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

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

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	50	0	0	0	0	0
Criteria	2	99	0	0	0	0	0

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



# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Maryann Rest Home and Hospital (Maryann) has policies, procedures and processes in place to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form including for photographs, outings, invasive procedures and collection of health information.</p> <p>Advance care planning, establishing and documenting enduring power of attorney (EPOA) requirements and processes for residents unable to consent is defined and documented where relevant in the resident's file. Staff demonstrated their understanding by being able to explain situations when this may occur. All residents' files reviewed in the secure unit had an activated enduring power of attorney (EPOA) or a Court appointed welfare guardian in place</p>

		Staff were observed to gain consent for day to day care on an ongoing basis.
<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>During the admission process, residents and resident's family members are given a copy of the Code, which also includes information on the Advocacy Service. Brochures on the Advocacy Service were displayed and available at reception. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.</p> <p>Staff were aware of how to access the Advocacy Service.</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 assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' families and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</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 complaints policy and associated forms meet the requirements of Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code). The information is provided to residents and families on admission and there is complaints information available at the main entrances. Six complaints have been received since the last audit and have been entered into the complaints register. Two complaints were reviewed and actions taken were documented and completed within the timeframes specified in the Code. Action plans reviewed evidenced any required follow up and improvements have been made where possible.</p> <p>The nurse manager (NM) is responsible for complaint management and follow up. Staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p> <p>There have been no complaint investigations by external agencies since the previous audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their</p>	FA	<p>Residents and family members of residents when interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussion with staff. The Code is displayed in common areas together with information brochures on the advocacy services and how to make a complaint.</p>

rights.		
<p>Standard 1.1.3: Independence, Personal 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>	FA	<p>Residents and family members of residents confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff understood the need to maintain privacy and were observed doing so throughout the audit, when attending to personal cares, ensuring residents' information is held securely and privately, exchanging verbal information and during discussion with families, the nurse practitioner (NP) and the general practitioner (GP). All residents have a private room.</p> <p>Residents are encouraged to maintain their independence by participating in community activities, regular outings to the local shops or areas of interest and participation in clubs of their choosing. Each plan included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed by staff and training.</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>There were four residents and several staff members at Maryann at the time of audit who identified as Māori. Interviews verified staff can support residents and staff who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau to Māori residents. There is a current Māori Health Plan developed which draws on the priorities set by the National Maori Health Strategy and the Taranaki District Health Boards (TDHB) Maori Health Strategy. One of Maryann's board members identifies as Maori and provides a direct link to the local iwi and to cultural advisors.</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</p>	FA	<p>Residents and their family members verified that residents were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences required interventions and special needs were included in all care plans reviewed, for example, food likes and dislikes and attention to preferences around activities of daily living. A resident satisfaction questionnaire includes evaluation of how well residents' cultural needs are met, and this supported that individual needs are being met.</p>

values, and beliefs.		
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. A nurse practitioner (NP) also expressed satisfaction with the standard of services provided to residents.</p> <p>The induction process for staff includes education related to professional boundaries and expected behaviours. All registered nurses (RN's) have records of completion of the required training on professional boundaries. Staff are provided with a Code of Conduct as part of their individual employment contract. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service encourages and promotes good practice through evidence based policies, input from external specialist services and allied health professionals, for example, hospice/palliative clinical nurse specialist, nurse practitioner, clinical nurse specialist from TDHB, psycho-geriatrician and mental health services for older persons, and education of staff. The NP confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support to access external education, in-service training sessions and online learning hubs, to support contemporary good practice.</p> <p>Other examples of good practice observed during the audit included a commitment to ongoing improvement in the care provided, evidenced by ongoing initiatives aimed at addressing the number of staff injuries and a reduction in the number of resident falls. An initiative aimed at reducing the number of medications some residents were taking, is an area recognised as one of continuous improvement.</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 of Maryann and their family members stated they were kept well informed about any changes to their own or their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. There was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p>

		<p>Interpreter services can be accessed via TDHB when required. Staff reported interpreter services were rarely required due to all residents being able to speak English.</p>
<p><b>Standard 1.2.1: Governance</b> The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The trust board is made up of seven trustees with various backgrounds. The business plan, currently under review includes a philosophy and mission statement and sets out the goals that are reviewed by the board. The philosophy and mission statement are in an understandable form and are displayed throughout the facility. An organisational and reporting chart sets out the structure of the organisation.</p> <p>The chief executive (CE), nurse manager (NM) and financial manager (FM) present reports at the two monthly board meetings. Review of the reports and interview of the CE confirmed this. The senior leadership team meet weekly to discuss a variety of activities relating to provision of services at Maryann. Interview of the CE and review of meeting minutes confirmed this.</p> <p>The facility is managed by a chief executive (CE) who has been in the position for two months. Prior to this role they were the service supervisor for seven years and continue to be responsible for the service. The CE reported being familiar with the role as they have worked closely with the outgoing CE. The CE reported they are booked to attend two management courses and attends the three-monthly leadership forums provided by the local DHB. The CE attended an Aged Care Association forum in February 2020. The CE also manages the organisation's sister facility two kilometres away and reported they visit three days per week and have frequent contact with staff.</p> <p>The management of clinical services is the responsibility of the nurse manager (NM) who has been in their role full time since January 2020. Prior to this, the NM job shared with another nurse manager. The annual practising certificate for the nurse manager is current. There was evidence in the NM's file of attending forums and conferences to keep up to date. The NM along with the clinical coordinator are also responsible for clinical oversight for the sister facility near-by. Documentation evidenced the change in CE and the NM to a fulltime role has been notified to HealthCERT.</p> <p>Maryann has a contract with the DHB for aged related residential care. The forty-six residents were under this contract (9 RH level residents including one younger person with a disability (YPD) resident, 22 hospital level including two YPD and 15 dementia care residents including one YPD). There were no residents under the long-term support-chronic health conditions or the residential respite services contracts.</p> <p>Of the 48 beds, two have been approved as dual purpose and are situated between the hospital area and the dementia unit. Currently the beds are occupied by hospital level residents.</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>	<p>FA</p>	<p>The CE reported when they are temporarily absent, the FM fills the role. When the NM is temporarily absent the clinical coordinator fills in. Support is provided by the board.</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>	<p>FA</p>	<p>The quality systems are well embedded at Maryann. Service delivery is linked to quality and risk throughout a number of documents including health and safety, clinical, incident and accidents and infection control. Quality and risk is managed via the senior leadership team, RNs and the health and safety meetings. Resident, health and safety, RNs, health care assistants and other staff meetings are held regularly and evidenced good reporting of clinical indicators, any trends and discussions around corrective actions. Meeting minutes reviewed were comprehensive with names of people responsible for any corrective actions, timeframes for completion and sign off. Any unfinished business is brought forward to the following meeting.</p> <p>The audit programme for 2019 and 2020 and completed audits were reviewed. Resident and family surveys for 2020 evidenced satisfaction with the service provided. Interviews of residents and families confirmed this.</p> <p>Quality data is entered electronically. Data is collated and analysed to identify any trends. Corrective actions are developed and implemented for deficits identified. Various graphs showing quality data trends are generated month by month.</p> <p>All documents are controlled. They are relevant to the scope and complexity of the service, reflected current accepted good practice, and reference legislative requirements. Footers show the currency of review. Staff receive alerts electronically and are encouraged to make comments while documents are in draft. Obsolete documents are archived electronically.</p> <p>Actual and potential risks are identified and documented in the hazard register, including risks associated with human resources management, legislative compliance, contractual risks and clinical risk and showed the actions put in place to minimise or eliminate risks. Newly found hazards are communicated to staff and residents as appropriate. Staff confirmed they understood what constituted a hazard and the process around reporting and documenting.</p>

<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>	<p>FA</p>	<p>Staff document adverse, unplanned or untoward events electronically. The CE and NM review and sign off following corrective actions developed and implemented. Documentation reviewed and interviews of staff indicated appropriate management of adverse events.</p> <p>Residents' files evidenced communication with families following adverse events involving the resident, or any change in the resident's condition. Families interviewed confirmed they were confident of being advised in a timely manner, as need be, following any adverse event or change in their relative's condition.</p> <p>Staff stated they are made aware of their essential notification responsibilities through job descriptions, policies and procedures, and professional codes of conduct. Review of staff files confirmed this. Policy and procedures comply with essential notification reporting. The CE advised there has been two essential notifications made to external agencies since the previous audit.</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>	<p>FA</p>	<p>Policies and procedures relating to human resources management are in place. Staff files included job descriptions which outline accountability, responsibilities and authority, employment agreements, references, completed orientation and police vetting.</p> <p>An orientation programme is provided. New health care assistants (HCA) are supported by a senior HCA who works alongside them as an initial 'buddy' and undertakes reviews of the HCAs progress. The NM and CC are responsible for the orientation of new RNs. Orientation for staff covers all essential components of the service provided.</p> <p>In-service education is provided for staff at least monthly and the programme covers all required topics. Documentation evidenced good attendance at all sessions. Specific topics relating to resident's health status is discussed at handover and during staff meetings. Outside educators take sessions and RNs attend sessions at the local DHB. Competencies were current including for medication management and restraint. Of the six RNs, four are interRAI trained and have current competencies. There is at least one staff member on each shift with a current first aid certificate.</p> <p>A New Zealand Qualification Authority education programme (Careerforce) is available for staff to complete and they are encouraged to do so. An external assessor is used, and HCAs have attained level two, three and four. All HCAs working in the dementia unit have completed the dementia specific modules. All staff have completed at least eight hours of ongoing training annually.</p> <p>Staff performance appraisals were current. Annual practising certificates were current for all staff and contractors who require them to practice.</p> <p>Staff confirmed they have completed an orientation, including competency assessments. Staff also confirmed their attendance at on-going in-service education and the currency of their performance</p>

		appraisals.
<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>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery. Staffing levels are reviewed constantly to meet the changing needs of residents and the layout of the physical environment. The senior leadership team are on call and staff make contact through a dedicated after-hours phone number. Care staff reported there is adequate staff available to complete the work allocated to them. Residents and families interviewed confirmed this.</p> <p>Observations and review of rosters confirmed adequate staff cover was provided, with staff replaced in any unplanned absence. The NM reported that, should there be a need, part time staff cover extra hours and there is a pool of casual staff as well to call on. Staff who have a current first aid certificate are identified on the rosters. The senior managers are all experienced RNs and the six RNs on the floor have all prior aged care experience ranging from seven to 32 years.</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's name, date of birth and National Health Index (NHI) number are used as the unique identifier on all residents' information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP, NP and allied health service provider notes. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. For the past three years, resident information has been collected and stored electronically. No personal or private resident information was on public display during the audit.</p> <p>Electronic records are stored in a secure portal.</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 enter Maryann when they have been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service, as requiring the care services provided by Maryann. Prospective residents and/or their families are encouraged to visit the facility prior to admission and meet with the nurse manager (NM), clinical co-ordinator (CC) or the clinical manager (CM). They are also provided with written information about the service and the admission process.</p> <p>Files of residents in the secure unit included a specialists referral authorising the provision of services</p>



		<p>and EPOA consent.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements.</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>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the TDHB's 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family. At the time of transition between services, appropriate information, including medication records and the care plan is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed transfer was managed in a planned and co-ordinated manner. Family of the resident reported being kept well informed during the transfer of their relative.</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>The medication management policy was current and identified all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the days of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by an RN against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Evidence is sighted of a reduction in the use of antipsychotics in residents in the secure unit, and ongoing monitoring and review of their use. (Refer 1.3.3.4)</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted included the prescriber's electronic signature and date recorded on</p>

		<p>the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP or NP review was consistently recorded on the electronic medicine chart.</p> <p>There were no residents who were self-administering medications at the time of audit. Appropriate processes were in place to ensure this can be managed in a safe manner if required.</p> <p>Medication errors are reported to the NM, CC, CM or RN and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.</p> <p>Standing orders are not used by Maryann.</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>	<p>FA</p>	<p>The food service is provided on site by a cook and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian in July 2018. Recommendations made at that time have been implemented.</p> <p>A food control plan was in place and registered with the Stratford District Council. A verification audit was undertaken 11 February 2020. No areas were identified as requiring corrective action.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, was available.</p> <p>Residents in the secure unit has access to food anytime night or day, as verified by observation, interviews and documentation.</p> <p>Evidence of resident satisfaction with meals is verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Any areas of dissatisfaction were promptly responded to. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There were enough staff on duty in the dining rooms at mealtimes to ensure appropriate assistance is available to residents as needed.</p>

<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>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.</p>	FA	<p>If a referral is received, but the prospective resident does not meet the entry criteria or there is no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed with the CC. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>On admission, residents of Maryann are initially assessed using a range nursing assessment tools such as pain scale, falls risk, skin integrity, nutritional screening and depression scale to identify any deficits and to inform initial care planning. Within three weeks of admission residents are assessed using the interRAI assessment tool, to inform long term care planning. Reassessment using the interRAI assessment tool, in conjunction with additional assessment data, occurs every six months or more frequently as residents changing conditions require. For residents where the interRAI assessment tool is not the required tool of assessment, a range of clinical assessment tools are used to inform care planning. These are reviewed six monthly or as residents' needs change. Behaviour assessments were sighted in the files reviewed of residents in the secure unit.</p> <p>In all files reviewed, initial assessments are completed as per the policy and within 24 hours of admission. In nine of eleven files reviewed the interRAI assessment was completed within three weeks of admission and at least every six months unless the resident's condition changed. Interviews, documentation and observation verified the RNs were familiar with requirements for reassessment of a resident using the interRAI assessment tool.</p> <p>Seven of eleven residents reviewed have current interRAI assessments completed by four trained interRAI assessors on site (Refer 1.3.3). InterRAI assessments are used to inform the care plan of these residents.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. In particular, the needs identified by the interRAI assessments were reflected in the care plans reviewed.</p> <p>Behaviour management plans, with identified triggers were sighted in the care plans of residents in the secure unit.</p> <p>Care plans evidenced service integration with progress notes, activities notes, medical and allied</p>

		health professionals' notations clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	Documentation, observations and interviews verified the care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The NP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs.
<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 activities programme is provided by two trained diversional therapists and an activities assistant. Activities are provided seven days a week</p> <p>A social assessment and history are undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The residents' activity needs are evaluated regularly and as part of the formal care plan review every six months. Residents in the secure unit have a 24-hour activity plan in place</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Examples included exercise sessions, daily walks, interaction with other care homes, interaction with visiting children's groups, men's shed, outings, picnics, beach buggy rides, visiting entertainers, quiz sessions and daily news updates. Activities for residents under 65 years, focus on assisting them to maintain previous lifestyle patterns. The activities programme is discussed at the residents' meetings and minutes indicated residents' input is sought and responded to. Resident and family satisfaction surveys demonstrated satisfaction and that information is used to improve the range of activities offered. Residents interviewed confirmed they find the programme meets their needs.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans</p>	FA	Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.

<p>are evaluated in a comprehensive and timely manner.</p>		<p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short-term care plans were sighted and evidenced consistent reviews for infections, pain, and weight loss with progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans were evaluated each time the dressing was changed. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a main medical provider, residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP, NP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to older persons' mental health services. Referrals are followed up on a regular basis by the RN, NP or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>Documented processes for the management of waste and hazardous substances were in place. Policies and procedures specify labelling requirements in line with legislation. Material safety data sheets are throughout the facility and accessible for staff. The company representative that supplies chemicals, visits regularly and provides training. Education to ensure safe and appropriate handling of waste and hazardous substances has been provided to staff.</p> <p>There was protective clothing and equipment appropriate to recognised risks and was sighted in the sluice rooms and the laundry and were being used by staff. Staff demonstrated a sound knowledge of the processes relating to the management of waste and hazardous substances.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit</p>	<p>FA</p>	<p>A current building warrant of fitness was displayed at the main entrance. There were appropriate systems in place to ensure the residents' physical environment and facilities are fit for purpose. Residents and families stated they can move freely around the facility and that the accommodation meets their needs.</p> <p>A proactive maintenance programme is in place and a reactive maintenance book for staff to enter any maintenance required has corrective actions completed and sign off. Plant and equipment are</p>

<p>for their purpose.</p>		<p>maintained to an adequate standard. Testing and tagging of equipment and calibration of biomedical equipment was current. Hot water temperatures are within the recommended range.</p> <p>Care staff confirmed they have access to appropriate equipment, that equipment is checked before use and they are competent to use it.</p> <p>Residents and families confirmed they know the processes they should follow if any repairs/maintenance are required and that requests are appropriately actioned.</p> <p>There are external areas available that are safely maintained and are appropriate to the resident groups and setting. All ramps have safety railing provided. The environment was conducive to the range of activities undertaken in the areas.</p>
<p>Standard 1.4.3: Toilet, 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>FA</p>	<p>Three bedrooms have a full ensuite and all rooms have a wash hand basin. There are adequate numbers of communal bathrooms and toilets throughout the facility. Residents reported that there are enough toilets and they are easy to access with vacant/engaged signage.</p> <p>Appropriately secured and approved handrails are provided, and other equipment is available to promote resident's independence.</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>	<p>FA</p>	<p>Bedrooms provide single accommodation with a mix of sizes. There is adequate personal space provided for residents and staff to move around safely within the bedrooms. Residents and families spoke positively about their or their relative's accommodation. Rooms are personalised with furnishings, photos and other personal adornments.</p> <p>There is room to store mobility aids such as mobility scooters and wheelchairs for those residents who require them.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and</p>	<p>FA</p>	<p>There are numerous areas for residents and families to frequent for activities, dining, relaxing and for privacy. The areas are easily accessed by residents and staff. Residents and families confirmed this. Furniture is appropriate to the settings and arranged in a manner which enables residents to mobilise freely.</p>

<p>accessible areas to meet their relaxation, activity, and dining needs.</p>		
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>Personal laundry is washed on site. All other laundry is supplied and laundered by an external company. Residents and families reported the laundry is managed well and residents' clothes are returned in a timely manner.</p> <p>Cleaners and laundry staff have received appropriate education and demonstrated a sound knowledge of processes. The facility is cleaned to a satisfactory standard and residents, families and the results from the 2020 satisfaction survey confirmed this. Chemicals were stored securely with a closed system used. All chemicals were in appropriately labelled containers. Cleaning and laundry processes are monitored through the internal audit programme and by personnel from the external company that supplies the chemicals.</p>
<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>	<p>FA</p>	<p>Documented systems were in place for essential, emergency and security services and considers the needs of residents with dementia. External lights are positioned around the facility. The front entrance doors automatically lock in the evenings and staff secure the other external doors. Staff carry out security checks.</p> <p>A New Zealand Fire Service letter approving the fire evacuation scheme was sighted. Trial evacuations are held at least six monthly and staff have received on-going training. At least one staff member is on each shift who has a current first aid certificate. Review of staff education spread sheets and rosters confirmed this.</p> <p>Information in relation to emergency and security situations is readily available/displayed for service providers and residents. Emergency supplies and equipment are checked six monthly by the maintenance person and good stocks of supplies were sighted. Emergency supplies and equipment included lighting, torches, gas for cooking, extra food supplies, emergency water supplies that meet the Ministry of Civil Defence and Emergency Management recommendations for the region, and blankets, cell phones and battery powered emergency lighting.</p> <p>A call bell system is in place that is used by the residents or staff to summon assistance if required and is appropriate to the resident groups and settings. Call bells are accessible/within reach and were available in resident areas. Residents confirmed they have a call bell system in place which is accessible, and staff respond to them in a timely manner.</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>	<p>FA</p>	<p>The facility is heated by ducted gas and bedrooms have individual outlet vents. Procedures are in place to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Residents and families confirmed the facility is maintained at an appropriate temperature. Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p> <p>A covered area outside the building is available for smokers.</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>	<p>FA</p>	<p>Maryann provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, developed at organisational level with input from the NM, CC, CM and the infection control co-ordinator. The infection control programme and manual are reviewed annually.</p> <p>An RN is the designated infection control coordinator (ICC), whose role and responsibilities were defined in a job description. Infection control matters, including surveillance results, were reported monthly to the NM, CC and CM and tabled at the quality/risk meeting. Infection control statistics are entered in the organisation's electronic database. The organisations NM and Chief Executive Officer (CEO) is informed of any IPC concern.</p> <p>Signage at the main entrance to the facility requests anyone who is, or has been unwell, has been overseas to countries with COVID-19 or in contact with people who have been in countries with COVID-19 not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities.</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>	<p>FA</p>	<p>The ICC has appropriate skills, knowledge and qualifications for the role and has undertaken training in infection prevention and control and attended relevant study days, as verified in training records sighted. Well-established local networks with the infection control team at the DHB are available and expert advice from an external advisory service is available if additional support/information is required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The ICC confirmed the availability of resources to support the programme and any outbreak of an infection.</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>	<p>FA</p>	<p>The IPC policies reflected the requirements of the IPC standard and current accepted good practice. Policies were reviewed within the last year and included appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves, as was appropriate to the setting. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</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>	<p>FA</p>	<p>Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation and documentation verified staff have received education in IPC at orientation and ongoing education sessions. Education is provided by suitably qualified RNs and the ICC. Content of the training was documented and evaluated to ensure it was relevant, current and understood. A record of attendance was maintained. When an infection outbreak or an increase in infection incidence has occurred, there was evidence that additional staff education has been provided in response. An example of this occurred when there was a recent increase in urinary tract infections.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell and increasing fluids during hot weather.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and skin infections. When an infection is identified, a record of this is documented in the resident's clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>The ICC, NM, CC and CM review all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via quality and staff meetings and at staff handovers. Surveillance data is entered in the organisation's electronic infection database. Graphs are produced that identify trends for the current year, and comparisons against previous years. Data is</p>

		<p>benchmarked internally.</p> <p>A 2019 analysis of infection data identified an increase rate of upper respiratory tract (URTI) infections in May and July despite a good uptake of the flu injection. It was noted 30 residents who had the flu injection still had an URTI, while 11 residents who had URTI had not had the flu injection.</p> <p>There's been no norovirus outbreaks at Maryann in the past eighteen months.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service demonstrated that the use of restraint is actively minimised. Equipment used included sensor and landing mats and low beds. There were four residents using restraint and two residents using an enabler during the audit. The CE and NM stated the aim was to have no restraint use in the facility. The restraint coordinator demonstrated good knowledge relating to restraint minimisation. The restraint/enabler register was current. Policies and procedures have definitions of restraints and enablers. Staff demonstrated good knowledge about restraints and enablers and knew the difference between the two.</p> <p>The restraint approval group forms part of the RN meetings. Restraint is also an agenda item at the HCA meetings. Meeting minutes and staff confirmed this.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>The use of restraint is approved by an RN, the resident's family and GP prior to commencing the restraint. The GP completes three-monthly reviews of restraints in use. A signed job description for the restraint coordinator was evident on file and in the restraint folder. Responsibilities of the restraint coordinator and approval group are clearly outlined.</p> <p>Restraint use is discussed in the RN, HCA and health and safety meetings. Staff confirmed their knowledge of the restraint processes.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>The electronic files of residents using restraint and enablers were reviewed. Restraint assessment plans were comprehensive and were completed prior to commencing restraint. Risk factors were identified in the assessment and the purpose of the chosen restraint was documented. Long term care plans clearly documented any risk and desired outcomes. Staff demonstrated good knowledge in maintaining culturally safe practice when completing assessments for restraint use.</p>

Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	Restraint minimisation policies and procedures are accessible for all staff to read. Safe use of restraint is actively promoted. There was a current and updated restraint/enabler register. Monitoring forms were completed electronically and included any risk factors and ensured the resident's safety while using restraint. Staff demonstrated good knowledge about restraints and strategies to promote residents' safety while using restraint. There were no restraint-related injuries reported.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	Residents using restraints and enablers are evaluated at least six-monthly in line with the resident's care plan. The evaluation form included the effectiveness of the restraint and the risks documented in the long-term care plans. Staff confirmed their feedback was obtained by the restraint coordinator when evaluating the restraint in use. The restraint approval group/RNs evaluated the restraints in use at least monthly. Meeting minutes confirmed this.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	Restraint is monitored and reviewed at the RN meetings. Restraint is also monitored through the internal audit programme, six monthly. Identified issues are discussed at the RN, health and safety and HCA meetings with additional education to support staff if needed. Staff demonstrated sound knowledge relating to managing challenging behaviours and 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

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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
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>The clinical teams attended a study day on polypharmacy and the effects of polypharmacy on residents. Following this, six residents who were identified as being at high risk of falling, who were observed to be sleeping a lot during the day, eating and drinking minimal amounts and participating very little in ongoing activities were reviewed in relation to polypharmacy. All residents were noted to be receiving a high number of pharmaceuticals. The NP in conjunction with the resident and family members agreed to do a review of each resident’s medications. Residents were supported by the expertise of the older persons’ mental health team when reviewing antipsychotic medications. Over a six-month time frame, gradual changes were made, with some medications being stopped, doses reduced or changed. All six residents have improved, with a reduction in falls, increased alertness and responsiveness, and increased quality of life. Family members of residents interviewed expressed a high degree of satisfaction with the improvement in their family member since being cared for at Maryann. Medication reviews remain ongoing.</p>	<p>The reduction in the use of medication by six residents has resulted in a reduction in falls, increased alertness during the day and improvements in quality of life.</p>

<p>Criterion 1.3.3.4</p> <p>The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.</p>	<p>CI</p>	<p>In June 2019 a review of the number of requests for acute GP visits to Maryann and acute transfers to the TDHB, identified 40 acute GP visits. Of these 40 visits, 16 did not require medical intervention, and one of the three residents transferred to the TDHB was returned after no medical input was required. The identified cause was related to lack of confidence and assessment skills by the RNs, most of whom were from overseas and not well equipped to work independently and without onsite GP support. Concerns were discussed with the NP and the NP was contracted to work with the RNs educating them around assessment skills, critical thinking and clinical decision making. The NP implemented the 'frailty care guide' and 'SBAR' tool to aid the RNs in assessment. Training was extended to include the healthcare assistants, to ensure improved knowledge around the need to escalate situations and seek additional assistance.</p> <p>A review in November 2019, showed a reduction in GP/NP visits by 55%, and TDHB admissions by 66%. The 26 acute visits and one admission to the TDHB all required medical intervention. The NP expressed a high level of satisfaction with staff's commitment to compliance with meeting the assessment guidelines in 'the frailty care guide' and staff's openness to learning. The NP has evidenced an improvement in ongoing nursing assessment at Maryann.</p>	<p>Improved nursing assessment has resulted in a decrease in acute visits by the GP/NP and a reduction in unnecessary transfers to the TDHB.</p>
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End of the report.