

Inglewood Welfare Society Incorporated - Marinoto Rest Home

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity: Inglewood Welfare Society Incorporated

Premises audited: Marinoto Rest Home

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

Dates of audit: Start date: 27 April 2021 End date: 28 April 2021

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 27

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

Marinoto rest home is a charitable trust governed by a trust board. Marinoto provides rest home and hospital level care for up to 32 residents. On the day of the audit there were 27 residents.

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

The clinical/facility manager (registered nurse) has been in the role nine months and is supported by a team of registered nurses and long-serving staff. The Trust Board Chairman and board members are actively involved in the operations of Marinoto rest home.

Residents and family interviewed complimented very positively on the care and services they receive.

This certification audit identified areas for improvement around aspects of the quality system, education, implementation of care and aspects of medication management.

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.

The service adheres to the Health and Disability Commissioner's Code of Health and Disability Consumers' Rights (the Code). The personal privacy and values of residents are respected. There is an established Māori health plan in place. Discussions with residents and relatives confirmed that residents and where appropriate their families are involved in care decisions. Regular contact is maintained with families including if a resident is involved in an incident or has a change in their current health. Families and friends are able to visit residents at times that meet their needs. Examples of good practice were provided. There is an established system for the management of complaints, which meets guidelines established by the Health and Disability Commissioner.

Organisational management

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

Some standards applicable to this service partially attained and of low risk.

Services are planned, coordinated, and are appropriate to the needs of the residents. The facility manager is responsible for day-to-day operations. There is a documented quality system.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. There is an education plan documented.

Registered nursing cover is provided 24 hours a day, 7 days a week. Residents and families reported that staffing levels are adequate to meet the needs of the residents.

The integrated residents' files are appropriate to the service type.

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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Residents/relatives confirmed the admission process, and the admission agreement was discussed with them on or prior to admission. The registered nurse is responsible for each stage of service provision. The assessments, care plans and evaluations are completed within required timeframes. The GP reviews the resident at least three-monthly. There is involvement of allied health professionals in the care of residents.

An activity coordinator is employed five days a week. The activities offered reflect the residents physical and cognitive abilities of the residents. Individual and group recreational preferences are accommodated. Community links are maintained.

Medication education and competencies are completed annually for the registered nurses and healthcare assistants responsible for administration of medicines. Medication policies reflect legislative requirements and guidelines.

All meals are prepared on site. Resident's individual food preferences, dislikes and dietary requirements are met. There is a dietitian review of the four-weekly menu. The cooks and kitchenhands are trained in food safety and hygiene.

Safe and appropriate environment

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

Standards applicable to this service fully attained.

The building has a current warrant of fitness. There is a planned maintenance programme in place. Staff have enough equipment to carry out resident cares safely. There is a mix of ensuite resident rooms and communal toilets/showers. All rooms are spacious and personalised. There are communal lounges and dining areas that are easily accessible. Cleaning and laundry are completed by dedicated staff seven days a week. Policies and procedures are in place for essential, emergency and security services, with adequate supplies should a disaster occur. There is staff on duty with 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.

Standards applicable to this service fully attained.

Staff regularly receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. A register is maintained by the restraint coordinator who is a registered nurse. No residents were using restraints and no residents were using enablers.

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.		Some standards applicable to this service partially attained and of low risk.
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The clinical team leader/registered nurse has responsibility for infection control across the service. The infection control coordinator coordinates education and training for staff. There is a suite of infection control policies and guidelines to support practice. Information obtained through surveillance is used to determine infection control activities and education needs within the facility. There have been no outbreaks.

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	39	0	4	2	0	0
Criteria	0	86	0	4	3	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
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Families and residents are provided with information on admission which includes information about the Health and Disability Commissioner's (HDC) Code of Health and Disability Consumers' Rights (the Code). Staff receive training about resident rights at orientation and as part of the annual in-service programme. Interviews with two board members and the facility manager and eight staff (three healthcare assistants (HCA) two registered nurses (RN), one clinical lead/RN, one cook and one diversional therapist) reflected their understanding of the Code with examples provided of how it is applicable to their job role and responsibilities. Five residents (four rest home and one hospital level) and two relatives interviewed of hospital level residents, confirmed that staff respect their privacy and support residents in making choices.
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	Residents and their families are provided with all relevant information on admission. Discussions are held with the resident and their representative regarding informed consent, choice and options regarding clinical and non-clinical services. Written general consents including outings and photographs were sighted in the six resident files reviewed (two hospital level including one short-term ACC respite and four rest home including one respite care resident). Resuscitation forms were appropriately signed by the resident and general practitioner (GP).

		<p>Signed admission agreements sighted also gives permission granted for release of medical information.</p> <p>Discussion with residents and relatives identified that the service actively involves them in decisions that affect the lives of the resident.</p>
<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>Residents interviewed confirmed they are aware of their right to access independent advocacy services. Discussions with relatives confirmed the service provided opportunities for the family/enduring power of attorney (EPOA) to be involved in decisions. The resident files include information on resident's family/whānau and chosen social networks.</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 and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. The activities programme includes opportunities to attend events outside of the facility. Residents are supported and encouraged to remain involved in the community. Relatives and friends are encouraged to be involved with the service and care.</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 that describes the management of the complaints process. Complaints forms are made available at reception. Information about complaints is also provided on admission. Interviews with residents and families confirmed their understanding of the complaints process. The facility manager was able to describe the process around reporting complaints, which complies with requirements of the Health and Disability Commissioner (HDC).</p> <p>Two complaints were registered in 2020 and none 2021 (year-to-date). The two complaints reflected evidence of acknowledgement, a comprehensive investigation and communication with the complainant within the timeframes determined by HDC. Staff are kept informed in meetings, evidenced in meeting minutes.</p> <p>There was one health and disability commissioner complaint around a complaint from a senior nurse regarding another senior nurse at the service (one has now left the service and the other was leaving the day after the audit) the nursing council has also been informed. The service has sent all requested information to the commissioner.</p>
Standard 1.1.2: Consumer Rights During	FA	<p>There is an information pack given to prospective residents and families that includes</p>

<p>Service Delivery</p> <p>Consumers are informed of their rights.</p>		<p>information about the Code and their right to make a complaint. There is the opportunity to discuss aspects of the Code during the admission process. Residents and relatives interviewed confirmed that information is provided to them about the Code. Large print posters of the Code in English and in te reo Māori, are displayed in visible locations. The facility manager or the clinical manager discusses the information pack with residents/relatives on admission. Families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement .</p>
<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>A tour of the premises confirmed there are areas that support personal privacy for residents. Resident rooms are large with ample room for visitors. Staff were observed to be respectful of residents' privacy by knocking on doors prior to entering resident rooms. Residents and relatives interviewed confirmed that staff treat residents with respect.</p> <p>Resident preferences are identified during the admission assessment and include family involvement. Interviews with residents and family confirmed their values and beliefs were considered. This was also evidenced in the residents' files reviewed. Healthcare assistants interviewed could describe how choice is incorporated into resident cares. Training around abuse and neglect was provided April 2021, HCAs interviewed were able to discuss the services policy of zero tolerance to abuse.</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 Māori health plan policy for the organisation references local Māori health care providers and provides recognition of Māori values and beliefs. The service has established links with Tui Ora Ltd and Te Kohanga Marae. There were no residents who identified as Māori on the days of audit. Cultural training has not been provided since the last audit (link 1.2.7.5).</p> <p>Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Cultural needs are assessed during the admission process and are addressed in the care plan.</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</p>	FA	<p>An initial care planning meeting is carried out where the resident and/or whānau as appropriate are invited to be involved. Individual beliefs or values are discussed and incorporated into the care plan. Six monthly multidisciplinary team meetings occur to assess if needs are being met. Family is invited to attend. Discussions with relatives confirmed that residents' values and beliefs are considered. Residents interviewed confirmed that staff take into account their values</p>

their ethnic, cultural, spiritual values, and beliefs.		and beliefs.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	The staff employment process includes the signing of house rules. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues. The orientation programme provided to staff on induction includes an emphasis on privacy and personal boundaries
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	<p>The service is committed to providing services of a high standard. The facility manager and two board members interviewed described the family approach to care and how they aim to deliver a high standard of care. This was observed during the day with the staff demonstrating a very caring attitude to the residents. Residents interviewed stated they are very happy with the level of care provided. Policies and procedures are developed by a contracted aged care consultant. The policies and procedures meet legislative requirements. There is a verbal and written handover for every shift that details any significant events. A communication book is used to ensure staff are kept informed on daily matters.</p> <p>The service has made improvements since the previous audit including a new sensory garden, four new beds, a new syringe driver, and room renovations.</p>
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	<p>There is an accident/incident reporting policy to guide staff in their responsibility around open disclosure. Staff are required to record family notification when entering an incident into the system. The sample of adverse events reviewed met this requirement. Family interviewed confirmed they are kept informed following a change of health status of their family member or an adverse event.</p> <p>There is an interpreter policy in place and contact details of interpreters are available.</p>
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Marinoto Rest Home is owned by the Inglewood Welfare Society Incorporated (board of six committee executives). Marinoto Rest Home provides hospital (medical and geriatric) and rest home level care for up to 32 residents. There are 26 dual purpose beds (including the dual-purpose double room) and 6 rest home only beds. On the day of the audit there were 27 residents in total. There were 24 residents at rest home level and three at hospital level (including one ACC and one respite). The remainder of residents were all under the age-related

		<p>residential care (ARRC) contract.</p> <p>The service is managed by a facility manager/clinical manager (dual role), who is a registered nurse (RN) with a current practising certificate. She has been in the role since July 2020 and is supported by an experienced clinical team leader. The team leader was due to leave following the audit. The service has recruited for a replacement. The facility manager provides a monthly report to keep the Society up to date with progress (confirmed by two committee executives interviewed). There are six committee executives who meet monthly and have the ability to co-opt to other members as required. The facility manager reports directly to a board sub-committee and the board are available to the facility manager as required at other times.</p> <p>There is a documented business plan for 2021. The business plan includes continued environmental refurbishment and raising staff confidence and competence.</p> <p>The facility manager has attended at least eight hours of professional development relating to her role, she has a master's degree in nursing.</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>The clinical team leader covers during the temporary absence of the facility manager with additional support available from the board as needed.</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>	PA Low	<p>Regular formal and informal reports to the board were evidenced. The board members are very involved with the service ensuring good communication.</p> <p>The service's policies are purchased from an external aged care contractor who publishes updates as needed. Staff are informed regarding policy changes at meetings. The quality system has not been fully implemented at the time of audit.</p> <p>There are a series of meetings scheduled including monthly staff meetings and monthly quality meetings. Not all meetings documented that quality information was shared, however staff informed that they are fully informed regarding quality data. Covid information was documented in meetings and through staff education. The quality programme includes a comprehensive internal audit schedule, however not all audits had been completed and action plans not always documented where a shortfall was identified.</p>

		<p>Incident and accident and infection control data is collated monthly, and a report documented, this report is available to the board and to staff on noticeboards; however, missing is evidence of discussion at meetings. Falls have reduced for April, medication errors have remained consistent at an average of three a month, medication errors are documented as followed up very well.</p> <p>Annual resident surveys have been conducted, outcomes of meetings have been communicated to respondents and to staff. The most recent survey results(April 2021) documented a high level of satisfaction across all areas including feeling consulted on care, meals, skilled staff, feeling respected and the cleanliness of the facility.</p> <p>Health and safety policies are implemented. The service administrator is the health and safety representative. There are procedures to guide staff in managing clinical and non-clinical emergencies. External contractors and new staff undergo health and safety training during their orientation. There is an up to date hazard register. Health and safety is a regular agenda item in the staff meetings but not always discussed (link also to 1.2.7.5 for training).</p> <p>Falls prevention strategies are in place including (but not limited to): sensor mats, increased monitoring for those residents at high risk of falling, and the identification and meeting of individual resident needs.</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>	FA	<p>There is an incident/accident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise and debriefing. Individual incident/accident reports are completed for each incident/accident with immediate action noted and any follow-up action required.</p> <p>A review of ten incident/accident forms (skin tears, wandering resident, witnessed and unwitnessed falls) identified that the incident/accident forms were fully completed and include follow-up by a registered nurse. Neurological observations that followed protocol were documented, however not all observations followed the protocol (link 1.3.6.1).</p> <p>The care manager was able to identify situations that would be reported to statutory authorities. There have been no outbreaks since the previous audit. Section 31 reports have been completed for; a wandering resident (twice), a change of manager, a staff member who fell and fractured their arm and one for lack of available RNs.</p>
Standard 1.2.7: Human Resource	PA Low	Human resources policies include recruitment, selection, orientation and staff training and development. Six staff files reviewed (two RNs, two HCAs one cook and one activities person)

<p>Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>reflected evidence of reference checking, signed employment contracts and job descriptions, completed orientation programmes and annual performance appraisals. The orientation programme provides new staff with relevant information for safe work practice. Orientation is specific to the individual's job role and responsibilities.</p> <p>Current registered nursing staff and external health professionals (general practitioners, physiotherapist, pharmacists, podiatrist) practising certificates were sighted.</p> <p>There is an annual education and training plan that exceeds eight hours annually per staff member, however not all training has been provided over the last two years including health and safety, Treaty of Waitangi (or cultural care), informed consent and clinical assessment/care of a deteriorating resident (which was suggested by the GP). Competencies are completed.</p> <p>Registered nurses are supported to maintain their professional competency. Four of nine registered nurses have completed their interRAI training. Careerforce is supported, and a number of staff have completed this.</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>The human resources policy determines staffing levels and skill mixes for safe service delivery. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.</p> <p>The facility manager and clinical leader are rostered Monday to Friday and on call. There is an RN and a trained first aider on each shift. The activity staff also have first aid certificates.</p> <p>There is a senior HCA, plus two further HCAs on both the AM and the PM shift and there are two HCAs on duty at night.</p> <p>Residents and relatives stated there were adequate staff on duty. Staff stated they feel supported by the RNs. The GP stated staffing was adequate.</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 were 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. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public.</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>A needs assessment is required prior to entry for rest home or hospital level of care. The facility manager or registered nurses (RN) are responsible for the screening of residents to ensure entry is appropriate. Residents and relatives interviewed stated they received all relevant information prior or on admission and received a welcome booklet.</p> <p>The admission agreement reviewed aligns with the ARC contract. 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>The RN (interviewed) described the transfer documentation that is sent with the resident for discharge and transfers. Families were informed of transfers and encouraged to accompany the resident to hospital. Follow-up occurs to check that the resident is settled, or in the case of death, communication with the family is made and documented. A transfer for the respite care resident under non-weight bearing ACC contract had been arranged for admission to the rehabilitation ward at the DHB. All relevant documentation was provided to the receiving provider.</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>	PA Moderate	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Medications are stored safely in the medication room located in the hospital wing. The service implemented an electronic medication system in March 2020. The supplying pharmacy delivers the regular and 'as required' medication in robotic rolls for regular medications and blister packs for as required medications. The RN on duty checks medications against the electronic medication charts and signs this as checked.</p> <p>Senior healthcare assistants and RNs who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided annually. The RNs have completed syringe driver competencies and the service has purchased a syringe driver for palliative care residents as needed. The medication fridge has daily temperature checks recorded. The medication room air temperatures are taken and recorded daily. Temperatures are within the acceptable limits. There was no impress stock and no standing orders in use.</p> <p>A procedure is in place for the self-administration of medicines. On the day of audit there was one resident self-medicating with a self-medication competency completed for a nasal spray kept on their person.</p> <p>Ten electronic medications charts were reviewed. All medication charts met prescribing requirements including indications for 'as required' medications. All medication charts had</p>

		photographic identification, but five charts did not have a documented allergy status. Not all eyedrops sighted in use had been dated. The GP/NP had reviewed the medication charts at least three-monthly.
<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>Food service policies and procedures met the requirements of the food control plan. The food control plan expires 25 June 2021. The service provides a meals-on-wheels service to the community. There is a qualified cook (chef with Bar 1 and 2 qualifications) Monday to Friday (7 am-2 pm) and a weekend cook. They are supported by morning and afternoon kitchenhands. Food services staff complete food safety orientation on employment and ongoing as part of the education programme.</p> <p>The rotating four-week summer and winter menu have been reviewed by a dietitian and includes normal and soft/pureed meals. The cook receives a dietary profile for each resident and is notified of any dietary changes. Residents' dislikes are accommodated. Pureed meals are provided. The kitchen is closely located to the main dining room. Meals are cooked and placed in a bain marie which is transported to the dining room for the serving of meals. The Tawa dining room has is a kitchenette with tea/coffee making facilities and fridge for fluids and provides an alternative dining area for residents who may require assistance/feeding.</p> <p>A daily food control plan of chiller, freezer and end cooked meat temperatures is completed as sighted. Food stored in the fridge and chillers is covered and dated. Dry goods and decanted, sauces and condiments are labelled with the re-filled and expiry dates. A cleaning schedule is maintained.</p> <p>Residents can feedback on the food services at the residents meeting. Residents/relatives interviewed spoke positively about the meals provided.</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>The referral agency and potential resident and/or family member would be informed of the reason for declining entry. The service policy for entry to services outlines the reasons for declining entry such as there are no beds available or where the acceptance of the admission could potentially affect other residents, or the home cannot provide the level of care required.</p>
Standard 1.3.4: Assessment	FA	The RN is responsible for completing initial assessments, relevant risk assessment tools and

Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.		interRAI assessments for long-term residents. Initial assessments had been completed within 24 hours of admission for all residents including the respite care and short-term ACC respite care residents. Relevant risk assessment tools falls, pressure injury, continence, pain (link 1.3.6.1), nutritional and behaviour assessments. Information gathered from the resident/relative, other health professionals and discharge/transfer documentation is used to form the basis of the care plans. The outcomes and supports identified in assessments are reflected in the care plans.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Low	<p>An initial assessment/support plan is completed within 24 hours in consultation with the resident/relative or support person. The initial support plan and input from care staff and allied health professionals involved in the care of the resident is used to develop the long-term care plans. Care plans are printed off the electronic resident management system and available in hard copy in the long-term resident files. Care plans identify the resident goals and nursing interventions to provide required supports (link 1.3.6.1). The long-term care plans reflect the interRAI assessment outcomes and triggers. Healthcare assistants interviewed were knowledgeable regarding resident cares and care plans.</p> <p>Allied health professionals involved in the resident care is reflected in the care plans with notes kept on file. Missing was documented evidence of resident/family/whānau involvement in the care planning development and evaluation process in the four long-term resident files reviewed.</p>
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Moderate	<p>Residents and relatives interviewed, reported that residents' individual needs were appropriately met, and they were kept informed of any changes to resident's health status, including incident/accidents, infections, medication changes, health professional visits and GP visits. Family/whānau/resident representative contact sheets were sighted in resident files and are maintained by the RN. When a resident's condition alters, the RN initiates a GP, NP or nurse specialist review. Healthcare assistants reported that they are informed of any changes in health status at handover, however not all interventions had been documented to guide staff in the care of residents needs/supports.</p> <p>Adequate dressing supplies were sighted. Wound management policies and procedures are in place. Wound assessments and evaluations were in place for six residents with wounds including two abrasions, two chronic wounds, one abscess and one facility acquired stage 2 of the sacrum. The pressure injury risk assessment had not been completed post development of a pressure injury. The wound management plans (electronic) are available in each resident file and serve as the care plan for the wound. There has been district nursing service involvement</p>

		<p>in a chronic wound. There are adequate pressure relieving devices including air mattresses and cushions.</p> <p>Continence products are available and resident files included a continence assessment where appropriate.</p> <p>Observation charts and monitoring records available for use include pain, blood sugars, behaviour, food/fluid intake, turning charts, neurological observations, weight and bowel monitoring. Not all monitoring had been implemented for identified pain, wandering resident or neurological observations post unwitnessed falls.</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 activities coordinator (a level 3 HCA) has been in the role at Marinoto for five years and has almost completed the diversional therapy (DT) qualifications. She attends the regional DT support group and is on the committee for the DT conference to be held this year in New Plymouth. The activities coordinator works from 8.30 am to 3.30 pm Monday to Friday and coordinates and implements the rest home/hospital activity programme. Volunteers are involved in entertainment, bowls (as observed on the day of audit) and one-on-one time with residents.</p> <p>The activities programme is planned to reflect resident preferences, abilities and suggestions from the monthly resident meetings. Residents receive copies of the activity programme. Activities include (but not limited to); exercises, cards, board games, art and crafts, music, movies, bowls, knitting club and happy hour. One-on-one time is spent with residents who choose not to or are unable to participate in group activities. Community visitors include K9 friends, entertainers and church services. There are inter-home visits (for bowls competitions) and outings into the community such as cafés and scenic drives. An Ironside van (with wheelchair access) is hired for regular outings. Festive occasions and birthdays are celebrated.</p> <p>A resident social profile and cultural assessment is completed following admission and an individual activity plan developed. Activity plans are reviewed six-monthly as part of the six-monthly MDT review. Residents and relatives interviewed were positive about 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>Evaluation of care plans against resident goals is conducted by the RN with input from the GP, healthcare assistants and activities coordinator. Families are notified of any changes in the resident's ability to meet their desired goals, however there is no documented evidence of resident/relative involvement (link 1.3.5.3). The long-term care plans are evaluated at least six-monthly for long-term residents. There is at least a three-monthly review by the GP.</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>	FA	<p>Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Examples of referrals sighted were to hospice, speech language therapist and respiratory clinical nurse specialist. The respite care resident under non-weight bearing ACC contract was being supported to attend orthopaedic appointments at the rehabilitation ward at the DHB.</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>	FA	<p>The service has waste management policies and procedures for the safe disposal of waste and hazardous substances. There is an incident reporting system that includes investigation of incidents. There is a locked chemical store and cleaners' room. The sluice room with a sanitiser and a locked cupboard for chemical bottles is located in the hospital/dual purpose wing. There is a sluice tub in the laundry which is located in the main rest home. There was appropriate protective equipment and clothing available for staff. Staff have attended chemical safety training.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building has a current building warrant of fitness that expires 8 April 2022. The responsibility for maintenance is overseen by the financial administrator who reports to board member (who is actively involved in the home maintenance, gardens and grounds). Staff record requests for repairs in a maintenance request book that is checked daily and actioned. There is a planned maintenance schedule in place that includes electrical testing, calibrations of clinical equipment and hot water testing. Hot water testing has occurred as per schedule and any variances outside the acceptable range is reported to the board member. Essential contractors are available 24 hours. Refurbishment of the older existing rooms and hallways have been completed.</p> <p>There is sufficient space for residents to safely mobilise using mobility aids and communal areas are easily accessible. There is safe access to the outdoor areas where seating and shade is provided. The landscaping around the recently built wing has been completed and includes a sensory garden, raised garden beds and seating.</p> <p>The healthcare assistants interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the residents' care plans including hoists, pressure relieving equipment and a recently purchased bariatric wheelchair.</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>	FA	<p>There are 10 resident rooms in the newly opened Tawa wing. Eight rooms have full ensuites. One room has a toilet ensuite and one room is a standard room with a communal toilet/shower facility located close by. The remaining rest home resident rooms have some with ensuites. All other rooms have hand basins. There are sufficient numbers of communal toilets and showers large enough to accommodate hospital level residents in dual purpose beds in the rest home. There are privacy curtains and privacy locks in all shower rooms.</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>Resident rooms are spacious enough to accommodate hospital level residents and transferring equipment in the designated dual-purpose rooms. Residents can safely manoeuvre using mobility equipment in rest home rooms. The bedroom doors are wide enough for the use of a hoist and for ambulance trolley access. There is one double room for either rest home or hospital level residents.</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>There is a main lounge and conservatory in the rest home and a main dining area. There is an open plan lounge and smaller dining room with kitchenette in the Tawa wing. There is a family/whānau room with access to the deck area outside from the sliding doors. The dining room kitchenette has tea/coffee making facilities for families. There are seating nooks throughout the facility. Activities take place in the dining rooms and lounges. There is safe access to the gardens and grounds.</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>	FA	<p>There is a dedicated cleaner 9 am to 1 pm seven days a week. The cleaner's trolley is stored in the locked chemical room in the rest home area, when not in use. The laundry has a defined clean and dirty area with entry and exit door. All personal clothing and linen are laundered on site by a home assistant, seven days a week. Care staff complete laundry duties such as ironing, as time permits on night shift. A volunteer assists with folding laundry. Personal protective equipment is available for cleaning and laundry duties. The chemical provider monitors the chemical supply and effectiveness of cleaning and laundry processes and provides chemical safety training.</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>	FA	<p>The fire evacuation scheme was approved 18 November 2019. All staff have completed six monthly fire drills.</p> <p>There are emergency management plans in place to ensure health, civil defence and other emergencies are included. There are sufficient civil defence and pandemic/outbreak supplies sighted. Civil defence supplies held in a cupboard are checked monthly. There is sufficient food for up to three days, held in the kitchen and second pantry. There is electric and gas cooking in the kitchen with two gas barbeques and spare gas bottles available. There is a 3,000-litre water tank installed under the new build (Tawa wing). The automated system pumps tank water into the facility which is used by the services and the tanks refill with fresh water. There is an onsite generator that is checked monthly by a contractor.</p> <p>There is at least one person on duty at all times with a current first aid certificate. There are call bells in all resident rooms, ensuites and communal bathroom facilities. There is an emergency call system. The location of the calls is displayed on corridor lighting boards. The call bell system is monitored 24 hours and the service completes monthly call bell audits. The automatic doors are locked at night and all external doors are alarmed. There is external lighting around the new wing and cameras in the corridors and lounge that can be viewed in the administration office.</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>There is adequate natural light in all resident rooms and communal rooms. Bedrooms have an external window and the communal dining room and family room in Tawa wing have doors that open to allow for ventilation. There are a number of resident rooms that open out onto decks. There is a gas fire in the lounge. Central heating is sensor monitored and adjusted to maintain a comfortable environment throughout the facility. There is night lighting in the corridors. There are air conditioning and heat pump units installed.</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>	PA Low	<p>The RN has responsibility for infection control which is described in the job description. The infection control coordinator oversees infection control for the service and is responsible for the collation of infection events. Review of the infection control programme has not been completed for the past year.</p> <p>Visitors are asked not to visit if unwell. There is QR screening and a declaration register at the main entrance for visitors and contractors. Hand sanitisers are appropriately placed throughout the facility. Residents are offered the 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 control coordinator completed an infection control course prior to the appointment 18 months ago. There is access to infection control expertise within the DHB, wound nurse specialist, district nurses and an external aged care consultant.</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>The service has infection control policies developed by an aged care consultant. The infection control manual includes a comprehensive range of standards and guidelines including defined roles and responsibilities for the prevention of infection, and training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. There are Covid-19 resources and DHB guidelines for the management of aged care facilities at all alert levels.</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 coordinator provides infection control orientation for newly appointed RNs, and care staff complete infection control orientation with their orientating "buddy". Infection control is included as part of the annual training schedule. There has been additional education on Covid-19 protocols, personal protective equipment and isolation procedures for staff and residents. Staff complete annual hand hygiene competencies.</p> <p>Resident education is expected to occur as part of providing daily cares.</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>	FA	<p>There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. The entering of data has recently commenced being entered into an electronic system that benchmarks infection events against industry standards. Infection control data including trends and analyses is discussed at the monthly staff meeting, however there is inconsistent reporting of discussion of data in meeting minutes (link 1.2.3.6). Infection rates are generally low. The GP monitors the use of antibiotics.</p>

		<p>There have been no outbreaks. There is sufficient personal protective equipment.</p> <p>Systems in place are appropriate to the size and complexity of the facility.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Restraint practices are only used where it is clinically indicated, and other de-escalation strategies have been ineffective. Restraint minimisation policies and procedures are comprehensive and include definitions, processes and use of restraints and enablers. The restraint coordinator is a registered nurse.</p> <p>The service is restraint-free and there are no residents with enablers.</p> <p>Staff training is in place around restraint minimisation and enablers, falls prevention and management of challenging behaviours.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.5</p> <p>Key components of service delivery shall be explicitly linked to the quality management system.</p>	PA Low	<p>There is a quality system documented that includes linkages between different aspects of quality tasks and service delivery, however this has not been fully implemented. Discussion with staff suggests an informal process of information sharing.</p>	<p>(i) Not all internal audits have been completed according to the schedule.</p> <p>(ii) Not all meetings document that quality information is shared and discussed, examples include lack of incident and accident data and analysis, health and safety and internal audit information for the December, February and March staff meetings. Infection control was not documented for the December and March meetings. The quality meeting did not document discussion of incidents, health and safety and internal audit.</p>	<p>(i) Ensure that internal audits are completed according to the schedule.</p> <p>(ii) Ensure that meetings reflect information and discussion of the quality outcomes.</p> <p>90 days</p>

<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	<p>PA Moderate</p>	<p>The quality plan includes internal audits. Each audit tool includes a process to document and follow up action plans as needed; the follow-up process is not always documented.</p>	<p>Action plans have not been documented for all internal audits, where an issue was identified. Examples include: audits for August, September and October.</p>	<p>Ensure an action plan is documented and followed up where a shortfall is identified.</p> <p>60 days</p>
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	<p>PA Low</p>	<p>There is a documented education schedule, however not all training has been provided. As Covid-19 emerged in early 2020 and two further outbreaks occurred, later in 2020 and again in early 2021 when their rest home went into pre-cautionary lockdown, this caused a number of training opportunities to be delayed or cancelled. They are in catch up mode for any topic that was not able to be delivered in 2020. The manager states they are on track to meet the training requirements. Also a number of their healthcare assistants have completed level 2 and or level 3 through Careerforce in 2021. A further five are enrolling in Level 3/4 Aged Care specialty papers</p>	<p>Not all training has been provided over the last two years including health and safety, Treaty of Waitangi (or cultural care), informed consent and clinical assessment/care of a deteriorating resident (which the GP had suggested they should undertake).</p>	<p>Ensure all training is provided as per the schedule.</p> <p>90 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage,</p>	<p>PA Moderate</p>	<p>All medications are stored safely in a locked purpose-built medication room. The supplying pharmacy provides all medications prescribed. All medications were within the expiry date. Not all eyedrops in use were dated. All medication charts sighted had been reviewed by the GP/NP. All medication charts had photo identification and seven had an allergy status documented.</p>	<p>(i) Five electronic medication charts did not have an allergy status documented and (ii) not all eye drops in use had been dated on opening.</p>	<p>(i) Ensure allergies are documented on the medication charts and (ii) ensure all eye drops are dated on opening.</p>

disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.				30 days
<p>Criterion 1.3.5.3</p> <p>Service delivery plans demonstrate service integration.</p>	PA Low	Allied health professional notes including GP visits are recorded in the resident file. Family and residents interviewed stated they are consulted regarding developing care plans and the evaluation of care plans, however there is no documented evidence of resident/family involvement.	There is no documented evidence of resident/relative input into care planning and evaluation of care.	<p>Ensure there is documented resident/relative involvement in long-term care plans and evaluations.</p> <p>180 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Moderate	Monitoring forms were in use for identified needs to monitor a resident's progress towards meeting desired goals. Neurological observations had not always been completed following unwitnessed falls and there was no monitoring in place for one respite care resident with identified pain and one long-term care resident who wandered.	(i) Two of six unwitnessed falls did not have neurological observations completed as per protocol, (ii) There was no pain assessment or monitoring of pain for one respite care resident with identified pain on admission and requiring 'as required' analgesia and, (iii) There was no monitoring in place as per accident/incident corrective action plan for a resident who had wandered.	<p>(i) Ensure neurological observations are completed as per protocol and (ii)-(iii) ensure monitoring requirements are implemented to meet the resident's needs.</p> <p>90 days</p>
<p>Criterion 3.1.3</p> <p>The organisation has</p>	PA Low	There are policies and procedures in place that outline the infection control programme, however there is no	The infection control programme has not been reviewed within the	Ensure the infection control

a clearly defined and documented infection control programme that is reviewed at least annually.		evidence of an annual review of the programme.	last year.	programme is reviewed annually. 60 days
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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.

No data to display

End of the report.