Age Care Central Limited - Maryann Rest Home and Hospital

Introduction

This report records the results of a Surveillance 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:

Legal entity:	Age Care Central Limited
Premises audited:	Maryann Rest Home and Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 22 February 2022 End date: 23 February 2022

Proposed changes to current services (if any): There is a plan to build an extension to the current building in the near future for the provision of further aged-care services.

Total beds occupied across all premises included in the audit on the first day of the audit: 47

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

Maryann Rest Home and Hospital is certified to provide residential care for up to 49 residents. The facility is operated by Age Care Central Limited and is managed by a chief executive officer. Residents and families/whānau spoke positively about the service and care provided.

This surveillance 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/whānau, management, staff, and a nurse practitioner.

There were two areas requiring improvement from this audit related to policy and procedure review, and activities availability.

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.

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

The chief executive officer is responsible for the management of non-clinical complaints and the nurse manager if they are clinically based. A complaints register is maintained. There have been no complaints received through the Health and Disability Commissioner's office in the last 12 months. One complaint has been received through the Taranaki District Health Board and this has been addressed appropriately.

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.

Maryann Rest Home and Hospital is governed by a board of directors who are responsible for the service provided. Business, quality, and risk management plans are in place. The mission statement outlines the philosophy and goals of the organisation.

The chief executive officer, who has been in the role since 2020, is an experienced and suitably qualified person to manage the facility. The chief executive officer is supported by a nurse manager, a clinical manager, and a clinical coordinator. The nurse manager is responsible for the oversight of the clinical services in the facility. Service monitoring information provided to the governing body is regular and effective.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families/whānau. Adverse events are documented electronically with corrective actions implemented. Open disclosure was evidenced in documentation reviewed and confirmed at interview with residents and families/whānau. Actual and potential risks, including health and safety risks, are identified, and

mitigated. Policies and procedures are in place to support service delivery. Legal and regulatory essential notification requirements have been met.

Appointment, orientation, and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review.

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 and experienced registered nurses are rostered on call after hours.

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.

On admission to Maryann Rest Home and Hospital residents have their needs assessed by the multidisciplinary team within the required timeframes. Shift handovers and communication sheets guide continuity of care.

Electronic care plans reflect an individualised approach, based on the collection of a comprehensive and integrated range of clinical information. Acute 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 families interviewed reported being well informed and involved in care planning and evaluation.

An activity programme is provided, and 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. Registered nurses and care staff administer medications, 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.

There was a current building warrant of fitness in the reception area of the facility, expiry date 30 May 2022.

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.

The organisation has implemented policies and procedures that support the minimisation of restraint and meet all requirements of the restraint minimisation standard. There were no enablers or restraints in use at the time of audit and no restraint has been used in the facility since May 2021. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff

interviewed demonstrated a sound knowledge and understanding of the restraint and enabler processes and education on restraint is provided.

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.

Maryann Rest Home and Hospital undertakes surveillance of aged care specific infections. The results of surveillance are analysed with data 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	14	0	1	1	0	0
Criteria	0	36	0	1	1	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
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 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints policy and associated forms meet the requirements of Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code) and had been reviewed in a timely fashion. Information about the complaints process is provided to residents and families/whānau on admission and there is complaints information available at the main entrances. This was confirmed by residents and their families/whānau interviewed. Four complaints have been received over the last 12 months, including a complaint received via the TDHB. These have been entered into the complaints register. The complaints were reviewed during the audit. Actions taken by the operator were documented and completed within the timeframes specified in the Code. Action plans following the complaint evidenced any required follow up and improvements have been made where possible. The CEO is responsible for non-clinical complaints management and follow up and the NM for clinical complaints. Staff interviewed confirmed a sound understanding of the complaint process and what actions are required. The complaint received via the TDHB (in February 2021) has been fully addressed with the complainant and TDHB and this has been resolved and closed.
Standard 1.1.9: Communication	FA	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

Service providers communicate effectively with consumers and provide an environment conducive to effective communication.		evidence of resident and family/ whānau input into the care planning process. Staff understood the principles of open disclosure, which is supported by a policy and procedure that meet the requirements of the Code. The open disclosure policy is currently out of date and had not been reviewed in July 2021 as scheduled (refer criterion 1.2.3.4). 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.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	The company board is made up of three directors with various backgrounds including community, financial and healthcare experience. The business plan 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. The documents described annual and longer-term objectives and the associated operational plans. An organisational and reporting chart sets out the structure of the organisation. The CEO, NM and financial manager (FM) present reports to the two monthly board meetings. Information provided includes financial, risk management (including health and safety risks and COVID-19 pandemic preparedness) and human resources information. Review of the reports and an interview with the CEO confirmed this. The senior leadership team meet weekly to discuss a variety of activities relating to provision of services at Maryann. This was confirmed through interview with the CEO and review of meeting minutes. The facility is managed by a CEO who has been in the position since 2020. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The CEO confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through legal and regulatory forums, and COVID-19 information through the Ministry of Health and the TDHB. The CEO also manages another of the operator's facilities two kilometres away; this is in the process of being closed and now houses only five residents. The management of clinical services is the responsibility of the NM who has been in their role full time since 2020. The annual practising certificate for the NM was current. There was evidence in the NM's file of attending education and clinical forums to keep up to date as well attending internal education relevant to the role. The NM along with the clinical coordinator (CC) are also responsible for clinical oversight of the nearby facility. Maryann Rest Home and Hospital (Maryann) has contracts with the DHB for aged related residential care (ARRC) providing rest home and hospital level services, long-term chronic health conditions (LTCHC) for young persons with a disability, under 65, dementia care (D3), and short-term respite. There are 49 beds available at the facility, one of which is reserved for emergency respite. Occupancy during the audit was at 47 residents; 31 under the ARRC contract (12 rest home and 19 hospital), one under the LTCHC contract (hospital level) and 15 receiving dementia level care. There were no residents receiving services under the residential respite services contacts. Of the 49 beds, two situated between the hospital area and the dementia unit, have been approved as dual

		purpose. Currently the beds are occupied by hospital level residents.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Low	The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents, accidents and hazards, complaints, audit activities, a regular resident and family/whānau satisfaction survey, a staff satisfaction survey, and monitoring of outcomes including clinical incidents (infections, wounds, pressure injury, and falls). Resident meetings, health and safety, RNs, health care assistants and other staff meetings are held regularly and evidenced 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. Relevant corrective actions are developed and implemented to address any shortfalls. Staff reported their involvement in quality and risk management activities through meetings and audit activities. Family/whānau satisfaction surveys are completed annually. The most recent survey (January 2022) showed that in general families/whānau were satisfied with the service with some improvements required in the areas of the concerns/complaints process, activities during COVID-19 lockdown, cleanliness of the facility, and the telephone system. Corrective actions were implemented where possible and these are documented. The internal audit programme for 2021 and 2022 and completed audits were reviewed. 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 and these are shared at staff meetings and with the Board. 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; however, of the eight policy documents reviewed (related to open disclosure, staff skill mix, restraint, sexuality and intimacy, risk management, interpreter and translation, complaints, and human resources), only two had been reviewed in a timely manner (complaints and human resources). Obsolete documents are archived electronically. The CEO and NM were able to describe the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. Both are familiar with the Health and Safety at Work Act (2015) and have implemented requirements.
Standard 1.2.4: Adverse Event Reporting All adverse,	FA	Staff document adverse, unplanned or untoward events electronically. Corrective actions are developed and the CEO and NM (as appropriate) review and sign these off following implementation of the corrective actions. Documentation reviewed and interviews with managers and staff indicated appropriate management of adverse events.

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.		Residents' files evidenced communication with families/whānau following adverse events involving a resident, or any change in the resident's condition. Families/whānau interviewed confirmed they were advised of any adverse event or change in their relative's condition in a timely manner. Staff reported 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 NM advised there has been one essential notification made to an external agency in the last 12 months and this was confirmed on review of the documentation.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	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, police vetting, and COVID-19 vaccination status. An orientation programme is provided. New health care assistants (HCA) are supported by a senior HCA (who works alongside them as a 'buddy' undertaking initial review of their progress). The NM and CC are responsible for the orientation of new RNs and enrolled nurses (ENs). Orientation for staff covers all essential components of the service. Staff interviewed confirmed they have completed an orientation, including competency assessments and this was documented in staff personnel files. 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 (as COVID-19 restrictions allow), and RNs attend sessions at the local DHB (again as COVID-19 restrictions allow). Competencies were current including for medication management and restraint. Of the nine RNs, six are interRAI trained and have current competencies. There is at least one staff member on each shift with a current first aid certificate. A New Zealand Qualification Authority (NZQA) education programme is available for HCAs to complete, and they are encouraged to do so. An external assessor is used, and HCAs have attained level two, three and four qualifications. All HCAs working in the dementia unit have completed the required dementia specific modules and all staff have completed at least eight hours of ongoing training annually. Staff performance appraisals were current. Annual practising certificates were current for all staff and contractors who require them to practice. Staff interviewed confirmed their attendance at ongoing in-service education and the currency of their performance appraisals.

Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	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/whānau interviewed confirmed this. Observations and review of rosters confirmed adequate staff cover was provided, with staff replaced in any unplanned absence, except in the area of activities (refer criterion 1.3.7.1). The NM reported that, should there be a need, part time staff cover extra hours and there is a pool of casual staff who can be called upon. Staff who have a current first aid certificate are identified on the rosters, and these included all RNs, the EN, and senior HCAs. The RNs all have prior aged care experience ranging from six to 26 years.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. A safe system for medicine management using an electronic system was observed on the day 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. 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. 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. The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range. Good prescribing practices noted included the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three monthly NP review was consistently recorded on the electronic medicine chart. There were no residents at Maryann who were self-administering medications at the time of audit. Appropriate processes are in place to ensure this can be managed in a safe manner. Medication errors are reported to the RN and clinical coordinator (CC) 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. Standing orders are not used at Maryann.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	The food service at Maryann is provided on site by two cooks and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and was reviewed by a qualified dietitian on the 24th of February 2021. Recommendations made at that time have been implemented. Residents in the secure unit have access to food at any time night and day. An up-to-date food control plan is in place. A verification audit of the food control plan was undertaken virtually by the Stratford District Council on the 24th of November 2021. One area was identified as requiring corrective action relating to procedures around the management of allergens and the separation of gluten free products. This has been attended to and signed off by the verifier. The next verification audit is due in 18 months (9th of May 2023). 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 cooks have undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training. 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, is available. 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 are sufficient staff on duty in the dining rooms at mealtimes to ensure appropriate assistance is available to residents as needed.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and	FA	Documentation, observations, and interviews verified that the care provided to residents of Maryann 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 the NPs 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.

desired outcomes.		
Standard 1.3.7: Planned Activities 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.	PA Moderate	The planned activities programme at Maryann is provided by two diversional therapists and an activities assistant, seven days a week. However, since September 2021, the programme provided has been sporadic/disrupted due to illness, injury, annual leave and staffing shortages. The absence of a regular activities programme being provided is an area requiring attention. 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 resident's activity needs are evaluated regularly and as part of the formal care plan review every six months. Residents in the secure unit, have twenty-four-hour activities plans in place that addresses residents twenty-four hour needs and previous lifestyle patterns. 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 when Covid-19 restrictions permit, includes normal community activities. Individual, group activities and regular events are offered. Examples include exercises or daily walks, visiting entertainers, quiz sessions, sensory activities, music therapy, happy hour, church services, and daily news updates. The activities programme is discussed at the residents' meetings and minutes indicated residents' input is sought and responded to. Family satisfaction surveys evidenced a request for more variety regarding the activities being offered. Residents interviewed confirmed they find the programme meets their needs.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Residents' care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN. 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 are sighted of acute care plans being consistently reviewed when acute care concerns arise. Progress is evaluated as clinically indicated and according to the degree of risk. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.
Standard 1.4.2: Facility Specifications Consumers are provided with an	FA	A current building warrant of fitness was displayed at the main entrance - expiry date 30 May 2022.

appropriate, accessible physical environment and facilities that are fit for their purpose.		
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Surveillance of infections at Maryann 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 scabies. When an infection is identified, a record of this is documented in the resident's clinical record, and an acute care plan commenced. New infections and any required management plan are discussed at handover, to ensure early intervention occurs. Staff are informed via the electronic resident management system of any new infections, and any required actions. The infection control nurse and CC 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 RN, 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. A 2021 'RSV' outbreak resulted in 12 residents being infected. The facility was placed in isolation. Public Health and the Taranaki District Health Board (TDHB) were informed. Processes were reviewed and improvements made where needed. Covid-19 restrictions are imposed at Maryann. Each resident is restricted to two nominated visitors, who may visit within certain hours. They are required to have a vaccine pass, wear a mask, and have their temperature taken. Non-nominated or non-vaccinated visitors are enabled to visit residents in an outdoor space. A good supply of personal protective equipment is available. Maryann has processes in place to manage the risks imposed by Covid-19 and to care for a Covid-19 positive resident. Surveillance of staff using Rapid Antigen Testing (RAT) occurs weekly.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint policy has not been reviewed as required (refer criterion 1.2.3.4). The restraint coordinator who is a registered nurse, provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the role and responsibilities, and the organisation's policies, procedures, and practice. The service demonstrated that the use of restraint is actively minimised. Equipment used to achieve this included sensor and 'landing mats' and low beds. Restraint is used as a last resort only when all alternatives have been

		explored. Staff demonstrated good knowledge about restraints and enablers and knew the difference between the two. The restraint register was reviewed. No restraints or enablers have been used since May 2020 and none were observed to be in use during the audit. Enablers when in use, are the least restrictive and are used voluntarily at a resident's request. A similar process is followed for the use of enablers as is used for restraints. There were no enablers in use during the audit. 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.

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)
Criterion 1.2.3.4 There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.	PA Low	The footers of policy and procedure documents showed the currency of review. Of eight policy documents reviewed, only two had been reviewed and up to date. The manager was aware that the policy documents were not updated, there is a plan in place to review them to align with the new Ngā Paerewa: health and disability services standard.	Policy review is not being completed as scheduled leading to documents that are out-of-date.	Policy review is scheduled to make sure that documents are reviewed on time and are up to date. 90 days

Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	PA Moderate	A planned activities programme, based on residents' strengths, interests, skills and resources is in place at Maryann, to run seven days a week, however, is not being provided due to the activities staff not always being available to implement the programme. The staff specifically employed to run the programme have been sporadically unavailable since September 2021, and staff shortages has not enabled their replacement. On the two days of audit, the hospital/rest home programme ran for two hours in the morning, with no activities provided in the afternoon. The programme in the secure unit, ran in the morning on one day. The next day the caregiver provided activities when not performing care tasks. Interviews verified that there has been no regular activities in the unit in the afternoons since September 2021. A family satisfaction survey in January 2022, requested more variety in activities be offered. A discussion with the nurse manager (NM) regarding the absence of activities being provided, verified the above observations. Efforts are being made to minimise the impact for the residents by using outside entertainers, who meet the Covid-19 imposed restrictions, to come in and entertain residents, in addition to church services. The television is used to provide virtual activities. The temporary absence of permanent activities staff is due to resolve early March.	Activities at Maryann are not being provided on a regular basis as planned.	A planned activities programme is provided that facilitates residents' skills, strengths and interests. 60 days

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.