The Maples Lifecare (2005) Limited

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	The Maples Lifecare (2005) Limited
Premises audited:	Maples Lifecare
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 2 March 2016 End date: 2 March 2016

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: 58

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

Maples Lifecare is one of 22 facilities owned by the Arvida group. The manager has been in the role under the new ownership since December 2014, having previously been one of two owner/managers of Maples Lifecare. The manager (registered nurse) is supported by a full time clinical charge nurse, registered nurses and care staff. The service provides rest home level care for up to 78 residents across a 53 bed rest home area (one double room) and 25 serviced apartments. On the days of audit there were 48 residents in the rest home including two respite residents, and 10 rest home level residents in the serviced apartments.

This surveillance audit was conducted against the 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, family, management and staff.

Residents and families interviewed commented positively on the care and services provided to residents at Maples Lifecare.

The service has addressed nine of 10 findings identified at the previous certification audit around admission agreements and informed consent, education for staff, care plan interventions, medication documentation, competencies and self-medicating residents and calibration of medical equipment. Further improvements are required in relation to care planning.

This surveillance audit identified no further improvements requiring improvement.

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.

Care plans accommodate the choices of residents and/or their family. Open disclosure is practiced and families are informed appropriately. Complaints processes are implemented and managed in line with the Code.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.

Maples Lifecare is implementing a quality and risk management system that supports the provision of clinical care. Quality activities are conducted. Adverse events are managed with clinical follow up provided. There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

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.

The sample of residents' records reviewed provides evidence that the provider has implemented systems to assess, plan and evaluate care needs of the residents. Care plans demonstrate service integration. Resident files include notes by the GP and allied health professionals. Medication policies and procedures are in place to guide practice and these are fully implemented. The activities programme is facilitated by an activities co-ordinator and two activity assistants. The activities programme provides varied options and activities are enjoyed by the residents. The programme caters for the individual needs. Community activities are encouraged; van outings are arranged on a regular and resident rotational basis.

All food is cooked on site by the in-house cook. All residents' nutritional needs are identified, documented and choices are available and provided. Meals are well presented.

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 is a current building warrant of fitness.

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.

There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There is a restraint register and a register for enablers. There are no residents with restraint or enablers. Staff are trained in restraint minimisation and challenging behaviour management.

Infection prevention and control

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

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	18	0	0	1	0	0
Criteria	0	44	0	0	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 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Informed consent and advanced directives were recorded as evidenced in five resident files reviewed. Advised by staff that family involvement occurs with the consent of the resident. Residents and family interviewed confirmed that information was provided to enable informed choices and that they were able to decline or withdraw their consent. Resident admission agreements were signed. The service has addressed these previous audit findings.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is	FA	There is a complaints policy to guide practice which aligns with Right 10 of the Code. The manager leads the investigation of concerns/complaints. Complaints forms are visible and available for relatives/residents. A complaints procedure is provided to residents within the information pack at entry. The service has managed complaints received in 2015 with follow up, investigation and outcomes communicated to the complainants. The complaints register is up to date. Management operate an “open door” policy.

understood, respected, and upheld.		
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	There is a policy to guide staff on the process around open disclosure and for residents who do not have any family to notify. The manager and clinical charge nurse confirm that family are kept informed. Relatives stated they are notified promptly of any incidents/accidents. Resident meetings encourage open discussion around the services provided (meeting minutes sighted). There is access to an interpreter service as required.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Maples Lifecare provides care for up to 78 rest home residents within a 53 bed rest home area and 25 serviced apartments. On the day of audit there were 58 rest home residents which included 48 rest home area residents and 10 rest home residents in the serviced apartments. There were two respite residents and one resident under the age of 65. All residents were on age related contracts. The service has a business plan which is reviewed annually. The business plan identifies the purpose, values and scope of the business. The service has quality goals which are reviewed at the quality management meetings. The Arvida group purchased Maples rest home in December 2014. The manager was the previous owner/manager of the service. The nurse manager is a registered nurse and is supported by another manager, the clinical charge nurse, and care staff. The manager has completed at least eight hours of professional development.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management	FA	Maples Lifecare is implementing a quality and risk management system. The manager oversees the quality programme. The quality programme includes goals for 2016. The previous year's plan has been reviewed. There are policies and procedures implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Staff confirmed they are made aware of any new/reviewed policies. Assessment policies have been updated to include reference to the use of the interRAI assessment tool. Monthly quality meeting minutes sighted evidence discussion around accident/incident data, health and safety, infection control, audit outcomes, concerns and survey feedback. The service collates accident/incident and

system that reflects continuous quality improvement principles.		infection control data. Monthly comparisons, trends and graphs are displayed for staff information. The care staff interviewed were aware of quality data results, trends and corrective actions. Annual resident and relative surveys are conducted with positive results achieved for 2015. Results have been collated. There is an internal audit programme that covers all aspects of the service. A summary of internal audit outcomes is provided to staff. Corrective actions have been developed and implemented for all shortfalls in service identified. There is an implemented health and safety and risk management system in place including policies to guide practice. There is a current hazard register. Staff confirm they are kept informed on health and safety matters at meetings. Fall prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls.
Standard 1.2.4: Adverse Event Reporting 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.	FA	A sample of accident/incident forms for January 2016 was reviewed. There has been RN notification and clinical assessment completed within a timely manner. Accidents/incidents were also recorded in the resident progress notes. There is documented evidence the family had been notified promptly of accidents/incidents. The service collects incident and accident data and reports aggregated figures to the quality and risk meeting and the staff meeting. Staff interviewed confirm incident and accident data are discussed at the staff meeting and information and graphs are made available. Discussions with the manager confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications.
Standard 1.2.7: Human Resource Management Human resource management processes are	FA	There are human resources policies to support recruitment practices. Five staff files sampled contained all relevant employment documentation and included a registered nurse, three caregivers and the activities coordinator. Current practising certificate was sighted for all registered nurses and allied health professionals. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed believed new staff were adequately orientated to the service on employment. Employment documentation was evident in the sample of staff files reviewed.

conducted in accordance with good employment practice and meet the requirements of legislation.		There is an education planner in place for 2016. 2015 in-service training included over 8 hours of training. The clinical charge nurse has completed the interRAI training. Staff complete competencies relevant to their role. Educational requirements have been provided over the past two years including wound care and pain management. Attendance at education sessions has improved. Records of attendance are maintained. The service has addressed this previous finding.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. The manager and clinical charge nurse are on-site full time and available after hours. The three part time registered nurses are rostered on to cover the morning shift from Monday to Sunday. The caregivers, residents and family interviewed inform there are sufficient staff on duty at all times.
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	Maples Lifecare has comprehensive medication policies in place. Medication storage and administration follow safe guidelines. Medication reconciliation is completed on admission and the policy includes guidelines on checking medications on admission. Registered nurse and senior caregiver medication competencies have been completed annually. The service has addressed this previous finding. Ten medication charts were reviewed. Of the 10 medication charts sampled, all had photographic identification and included route of administration, which is an improvement on previous audit. Signing on administration was up to date, including as required medications (PRN). All PRN medications had indication for use identified on the medication chart. The RN administering medications was witnessed signing for resident medication given. This was a previous audit finding has now been addressed. There were no residents self-medicating. Identification of resident allergies is documented on all ten medication charts reviewed. Nine of ten medication charts reviewed had written evidence of the GP three monthly reviews, or more as conditions changed; one was a recent admission. All medication charts had been signed and dated. All packaged medications prescribed to be administered regularly were signed as being administered regularly. Weekly medication checks were documented; this is an improvement from previous audit.
Standard 1.3.13: Nutrition, Safe Food,	FA	The menu have been audited and approved by a dietitian. The service employs two cooks and kitchen assistants. Fridge and freezer temperatures are monitored and documented daily in the kitchen. All food containers are

And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.		labelled in the kitchen. Meals are prepared in the kitchen and delivered to the dining room. There are a range of policies in place. The residents have a nutritional profile developed on admission, which identifies dietary requirements, likes and dislikes. This is reviewed six monthly as part of the care plan review and communicated to the kitchen. Changes to residents' dietary needs are communicated to the kitchen as reported by the kitchen manager. Special diets are noted on the kitchen notice board which is able to be viewed only by kitchen staff. Special diets are catered for. Residents' interviewed stated that the food service was satisfactory.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	All residents are admitted with a care needs level assessment completed by the needs assessment and service co-ordination team prior to admission. Personal needs information is gathered during admission, which formed the basis of resident goals and objectives. Assessments are reviewed at least six monthly, or more as condition changes. Long term care plan reviews had been completed six monthly or as condition changed. InterRAI assessment has been completed for two permanent residents. One of five files was for a resident under 65 under Lifelinks and one resident was on respite care. Assessments and documentation is complete.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Moderate	The care plan format is comprehensive and policies and procedures are in place to guide staff. Interventions are not fully documented for all assessed needs. The previous audit identified findings around the signing and dating of care plans by registered nurses; care plan interventions for respite residents; and privacy for residents have all been addressed. Previous findings around weight monitoring and documented interventions and challenging behaviour monitoring and interventions remain findings at this audit. This audit also evidences gaps around falls prevention management, care plan interventions and wound care plans. GP reviews are documented three monthly and as needed.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services	FA	When a resident's condition changes, the registered nurses initiate a review and if required a GP or specialist consultation. The caregivers interviewed stated that they have all the equipment referred to in care plans and necessary to provide care. All staff report that there are always adequate continence supplies and dressing supplies. Residents and families interviewed were complimentary of care received at the facility.

in order to meet their assessed needs and desired outcomes.		The care being provided is consistent with the needs of residents; this is evidenced by discussions with caregivers, families interviewed, two registered nurses and the clinical manager. There are short-term care plans that are used for acute or short-term changes in health status. Long term care plan documentation was not fully completed (link #1.3.5.2). Dressing supplies are available and a treatment room is stocked for use. All wound charts identified frequency of treatment and evaluations, which is an improvement on the previous audit.
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.	FA	There is a diversional therapist who is contracted to work four days a week (Monday to Thursday, 0900 – 1700 hours). There is also an activity assistant, who works four days a week (Tuesday to Friday, 0930 – 1630 hours). There is a full and varied activities programme in place, which is appropriate to the level of participation from residents'. On the day of audit residents were observed being actively involved with a variety of activities. There is a regular, twice daily exercise programme and intergenerational activities with the local preschool. There is close documented involvement with the physiotherapist around individualised exercise programmes. The activity assistant is also the physio assistant. A number of volunteers assist delivering different parts of the activity programme. The activities programme is developed monthly, which is displayed in large print in communal areas and resident bedrooms. There are regular van outings and there is a roster, so all residents have an opportunity to go out. All residents and families interviewed voiced their satisfaction for the activities programme and felt that recreational needs were being met. Residents have an activities assessment completed over the first few weeks. Resident files reviewed identified that the individual activity plan is reviewed six monthly, or as condition changes.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Review and evaluation of care plans by an RN is conducted at least six monthly, or as changes to care occur. All initial care plans are evaluated by the RN within three weeks of admission. There is documentation evidence of family and/or resident involvement at these evaluations. Documentation on clinical notes evidence review by the GP at least three monthly. A sample of residents' files short-term care plans identified clear interventions directing staff in resident care. There are short-term care plans to focus on acute and short-term issues. From the sample group of residents' notes, the short-term care plans are generally well used and comprehensive. Examples of short-term care plan use included; infections, wounds and weight loss.
Standard 1.4.2:	FA	There is a current building warrant of fitness, which expires on 1 July 2016. Medical equipment including the blood pressure machines, thermometer and chair scales have been calibrated in August 2015. The service does not have

Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.		a hoist. The service has addressed this previous finding.
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	Infection surveillance is an integral part of the infection control programme and is described in the infection control manual. Monthly infection data is collected for all infections for each area based on signs and symptoms of infection. Short-term care plans are used. Surveillance of all infections is entered on to a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at all meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the nurse manager and clinical manager. There have been no outbreaks since the previous audit.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The service has documented systems in place to ensure the use of restraint is actively minimized. Enabler use is voluntary. There are no residents with restraint or enablers. Staff interviews and staff records evidence guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques. Restraint has been discussed as part of quality meetings. The clinical charge nurse is the designated restraint coordinator.

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 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	PA Moderate	Four resident long term care plans were reviewed; all had been individually developed with the resident and family/EPOA who signed to acknowledge their approval of the care plan. Residents and family members interviewed agreed that they are involved in the care planning process. Nursing diagnosis, goals and outcomes are identified and agreed and how care is to be delivered is explained in most.	Of the four care plans reviewed, the following shortfalls were identified: (i) Two did not have falls prevention strategies well documented ; (ii) One resident care plan did not identify care interventions for management of showering (even though, there was a documented need for assistance); (iii) Management of behaviour including wandering was not well documented in one care plan; (iv) Care plan interventions for documented weight loss was not documented for one resident; (v) One care plan continued to document a resident was self-medicating, however, this was no longer the case. (vi) The wound care plan for one resident has two wounds documented on it.	Ensure that care plan interventions are documented to guide staff in the provision of resident care and support including: (i) falls prevention strategies, (ii) hygiene care, (iii) management of behaviours that challenge, (vi) management of weight loss, (v) update with change of interventions around self-administering medications, and (vi) ensuring there are separate wound assessments and management plans for each wound. 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.