

# Mayfair Lifecare (2008) Limited - Mayfair Lifecare

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## Introduction

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

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

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

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

The specifics of this audit included:

**Legal entity:** Mayfair Lifecare (2008) Limited

**Premises audited:** Mayfair Lifecare

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

**Dates of audit:** Start date: 25 April 2016 End date: 26 April 2016

**Proposed changes to current services (if any):** The service has been assessed for an increase in the number of dual purpose beds from 34 to 37.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 83



# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Mayfair Lifecare is one of 22 facilities owned by the Arvida group. The facility manager has been in the role under the new ownership for one year, having previously worked as the clinical manager of Mayfair Lifecare. The service is certified to provide rest home and hospital (geriatric and medical) level care for up to 88 residents. There were 83 residents on the days of audit.

This certification 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, staff and the general practitioner. Three rest home only rooms were also verified at this audit as suitable to be used as dual purpose beds.

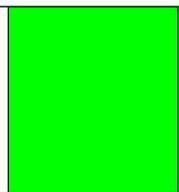
The facility manager works full-time and is supported by a clinical manager, a systems implementation coordinator, a compliance village and care centre manager and a quality support person.

Residents, families and the general practitioner interviewed commented positively on the care and services provided to residents at Mayfair Lifecare.

The certification audit identified improvements are required around incident reporting, care planning and interventions and aspects of medication management.

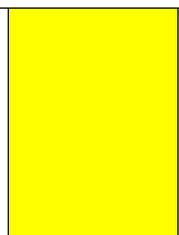
The service is commended for achieving a continued improvement rating around infection surveillance projects.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Mayfair Lifecare provides care in a way that focuses on the individual resident. Cultural and spiritual assessment is undertaken on admission and during the review processes. Policies are implemented to support individual rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. Residents and family interviewed verified ongoing involvement with the community. Information about the Code and related services is readily available to residents and families. Care plans accommodate the choices of residents and/or their family. 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.		Some standards applicable to this service partially attained and of low risk.
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Mayfair Lifecare is implementing a quality and risk management system that supports the provision of clinical care. Quality activities are conducted which generates opportunities for improvement. Corrective actions are developed and implemented. The service has a strong health and safety culture. 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.
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Service information is provided to the residents and their family on admission. The interRAI assessment process is being implemented to assess, plan and evaluate care needs of the residents. Care plans are developed by a registered nurse in consultation with the resident and/or family and are reviewed at least six monthly. Resident files include three monthly reviews by the general practitioner. There is evidence of other allied health professional input into resident care.

Medication policies reflect legislative requirements and guidelines. All staff responsible for administration of medicines completes education and medicines competencies. The medicines records reviewed include documentation of allergies and sensitivities and are reviewed at least three monthly by the general practitioner/nurse practitioner.

Activities programmes are provided for the rest home and hospital residents. The programme includes community visitors and outings, entertainment and activities that meet the recreational preferences and abilities of the residents.

All food and baking is done on-site. All residents' nutritional needs are identified and documented. Choices are available and are provided.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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A current building warrant of fitness is displayed. Residents' rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. Residents can and do bring in their own furnishings for their rooms. There are lounge and dining areas in the facility. There are also small seating areas throughout the facility. Furniture is appropriate to the setting and arranged that allows residents to mobilise.

There is a designated laundry with secure storage of cleaning and laundry chemicals. Chemicals are stored in a locked storage cupboard. The service has implemented policies and procedures for civil defence and other emergencies. Alternative power and cooking facilities are available in the event of a power failure. Communal living areas and resident rooms are appropriately heated and ventilated. Residents have access to natural light in their rooms and there is adequate external light in communal areas. External garden areas are available with suitable pathways, seating and shade provided.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Mayfair is aiming and working towards a restraint-free environment. Policy and procedures are in place. There is a designated restraint coordinator. Staff receives training in restraint minimisation and challenging behaviour management. On the day of audit, the service had four residents using restraint in the form of bedrails and no residents with an enabler.

## 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.

All standards applicable to this service fully attained with some standards exceeded.

Mayfair has robust infection control policies and procedures. All staff receives education at orientation. Infection control education is also included in the annual education plan. All staff are assessed at least annually on hand hygiene. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	1	45	0	3	1	0	0
<b>Criteria</b>	1	96	0	3	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Mayfair Lifecare has policies and procedures that align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code). Eight caregivers, two diversional therapists and three registered nurses (RN) were able to describe how they incorporate resident choice into their activities of daily living. The service actively encourages residents to have choices and this includes voluntary participation in daily activities as confirmed on interview with ten residents (seven rest home and three hospital).</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. Written consents are signed by the resident or their EPOA. Advanced directives are signed for separately and guide staff in relation to resuscitation status. There is evidence of discussion with family when the GP completed a clinically indicated not for resuscitation order. Caregivers and registered nurses interviewed confirmed verbal consent is obtained when delivering care. Discussion with family members identified that the service actively involves them in decisions that affect their relative's lives.</p> <p>Ten of ten resident files sampled (three rest home, and seven hospital) had signed consents. All resident files sampled contained a completed and signed admission agreement.</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 are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlet on admission. Interviews with residents and family confirmed they were aware of their right to access advocacy. Advocacy is discussed at resident meetings and information is available along with complaints forms and the process.</p> <p>Residents confirm that the service provides opportunities for the family/EPOA to be involved in decisions. The resident files sampled included information on the residents' family 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>Interview with residents confirm relatives and friends can visit at any time and are encouraged to be involved with the service and care. Residents are encouraged wherever possible to maintain former activities and interests in the community. They are supported to attend community events, clubs and interest groups in the community. Residents confirm the staff helps them access community groups.</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>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 received seven complaints in 2015 and three for 2016. These have been appropriately managed, with acknowledgement letters, letters of investigations conducted and outcomes achieved provided to complainants. The complaints register is up to date. Management operate an "open door" policy.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>There is a welcome pack provided to residents on entry that includes information on how to make a complaint, Code of Rights pamphlet, advocacy and Health &amp; Disability (HDC) Commission. Five relatives (two rest home and three hospital) and residents are informed of any liability for payment of items not included in the scope of the service. This is included in the signed service agreements. Residents and relatives interviewed confirmed they received all the relevant information during admission.</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>There are policies in place to guide practice in respect of independence, privacy and respect. Resident preferences are identified during the admission and care planning process with family involvement. Staff were observed to be respectful of residents' personal privacy by knocking on doors prior to entering resident rooms during the audit. Residents interviewed confirmed staff respect their privacy and support residents in making choice where able. Staff have completed education around privacy, dignity and elder protection.</p> <p>Resident files are stored securely. There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement.</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>Mayfair Lifecare has a Māori health plan included in the cultural safety policy that includes a description of how they will achieve the requirements set out in A3.1 (a) to (e). Residents who identify as Māori have this documented in their files and care plans include interventions to meet their cultural needs. Linkages with Māori community groups are available and accessed as required.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The resident and family are invited to be involved in care planning and any beliefs or values are further discussed and incorporated into the care plan. Care plans sampled included the residents' values, spiritual and cultural beliefs. Six monthly reviews occur to assess if the resident needs are being met. Discussion with family and residents confirm values and beliefs are considered. Residents are supported to attend church services of their choice.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Job descriptions include responsibilities of the position and signed copies of all employment documents are included in the nine staff files sampled. Staff complies with confidentiality and the code of conduct. The RN's and allied health professionals practice within their scope of practice. Management and staff meetings include discussions on professional boundaries and concerns/complaints as they arise (minutes sighted). Interviews with the manager, the registered nurse and care staff confirmed an awareness of professional boundaries. Registered nurse files reviewed attendance at professional boundaries and code of conduct training.</p>
<p>Standard 1.1.8: Good Practice</p>	FA	<p>Mayfair Lifecare policies and procedures meet the Health and Disability safety sector</p>

<p>Consumers receive services of an appropriate standard.</p>		<p>standards. Staff are made aware of new/reviewed policies and sign to say they have read them. An environment of open discussion is promoted. Staff reported the manager and registered nurses are approachable and supportive. Allied health professionals are available to provide input into resident care. Staff completes relevant workplace competencies. The RN's have access to external training. Discussions with residents and family were positive about the care they receive.</p> <p>Benchmarking takes place internally against previous years for incidents/complaints, infections and audit outcomes. Collated incident/accident reports are forwarded each month to the quality manager. Analysis of trends occurs and comprehensive monthly reports are written by the quality manager including ongoing review and analysis of corrective actions. Corrective action status is monitored and evaluated for effectiveness/signed out. This is reflective in comprehensive reports. There are a number of quality improvement projects running in 2016.</p> <p>Areas of improvement include a revamped and improved orientation programme with an emphasis on ongoing staff education. The Ace Achievement programme is an expectation for all care staff within six months of commencing employment. The service currently has 15 with their National Certificate and a further 16 with their core qualification. The staff education programme includes a number of self-learning tools along with regular in-service training provided by experts in their fields.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>There is a policy to guide staff on the process around open disclosure. The facility manager and clinical manager 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).</p> <p>There is access to an interpreter service as required.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Mayfair Lifecare provides care for up to 88 rest home and hospital (geriatric and medical) residents. On the day of audit, there were 83 residents, which included 50 rest home, and 33 hospital residents. Three rest home only rooms were also verified at this audit as suitable to be used as dual purpose beds. All rooms are of equal size. The dual purpose rooms are located in one central wing of the facility. As a result, the service has increased the number of dual purpose beds from 34 to 37 and decreased the number of rest home level care rooms from 54 to 51.</p>

		<p>There were two residents under the medical component – one on an ACC contract and one on an end of life contract. All other residents were under the ARCC agreement including one respite rest home resident.</p> <p>The service has a business plan for 2016. 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 Mayfair Lifecare in December 2014. The facility manager was the previous clinical manager of the service. The facility manager is a registered nurse and is supported by a clinical manager, a quality support person and two Arvida systems and compliance managers. The facility manager and the clinical manager have been in their respective roles for one year.</p> <p>The facility manager has completed at least eight hours of professional development related to managing an aged care facility.</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 manager provides cover in the absence of the facility manager, with support from the Arvida head office team.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>Mayfair Lifecare continues to implement a quality and risk management system. The facility manager and quality support person oversee the quality programme. The quality programme includes goals for 2016. The previous year's plan has been reviewed. The services quality focus has been the driver behind a significantly decreased medication error rate and a decrease in the UTI rate (link CI 3.5.7). The focus continued from mid-2015 and has been maintained.</p> <p>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.</p> <p>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 infection control data. Monthly comparisons, trends and</p>

		<p>graphs are displayed for staff information. The care staff interviewed were aware of quality data results, trends and corrective actions. All meeting minutes have a corrective action format and include actions to achieve compliance where relevant. This, together with staff training, demonstrates Mayfair Lifecare's ongoing commitment to continuous quality improvement. Analysis of their skin tear injury data has generated a project to reduce and this has commenced.</p> <p>In 2015 the service introduced a new monthly report for clinical and non-clinical indicators and quality meeting review. This includes benchmarking against age care indicators. Advised that this report helps them to better monitor their performance, identify emerging trends and generating improvements.</p> <p>Annual resident and relative surveys have been conducted. The overall results show that residents and relatives are very satisfied with the care being provided at Mayfair Lifecare.</p> <p>An internal audit programme covers all aspects of the service. A summary of internal audit outcomes is provided to staff. Corrective actions have been developed and implemented for shortfalls in service identified.</p> <p>There is an implemented health and safety and risk management system in place including policies to guide practice. The service has achieved WSMP tertiary level achievement. There is a current hazard register. Staff confirm they are kept informed on health and safety matters at meetings.</p> <p>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. Despite the introduction of an exercise programme called 'movement with meaning', the service is aware their current fall rate is still higher than what they would like and they are working to reduce this by way of current projects in progress. They have also provided additional education for staff.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>PA Low</p>	<p>A sample of accident/incident forms for March 2016 were 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. Not all pressure injuries were documented on an incident report and therefore not included as part of the benchmarking programme.</p> <p>The service collects incident and accident data and reports aggregated figures to the quality meeting and the health and safety meeting. Staff interviewed confirmed incident and accident</p>

		<p>data are discussed at the staff meeting and information and graphs are made available.</p> <p>Discussions with the management team confirm an awareness of the requirement to notify relevant authorities in relation to essential notifications.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are human resources policies to support recruitment practices. Nine staff files sampled contained all relevant employment documentation and included the clinical manager, one diversional therapist, one cook, three registered nurses and three caregivers. Current practising certificates were sighted for 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 advised that new staff were adequately orientated to the service on employment. Employment documentation was evident in the sample of staff files reviewed.</p> <p>There is an education planner in place for 2016 and is being implemented. Three registered nurses have completed interRAI training. Staff completes competencies relevant to their role. In 2015 the service implemented regular 'education talks' by the RNs for care staff on handover. These talks cover a wide range of best practice care topics to promote continuing learning, knowledge and care competency. This has continued into 2016. There are 31 of 35 caregivers that have a national qualification.</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 service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. The facility manager and clinical manager are on-site full-time and available after-hours. The registered nurses are rostered on 24/7. The caregivers, residents and family interviewed inform there are sufficient staff on duty at all times. Agency staff are used when required.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident files are appropriate to the service type. All relevant initial information is recorded within required timeframes into the resident's individual record. All resident records containing personal information is kept confidential. Entries were legible, dated and signed by the relevant caregiver or registered nurse including designation. Files are integrated.</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>	<p>FA</p>	<p>Mayfair Lifecare has policies and procedures to safely guide service provision and entry to services. Information gathered on admission is retained in residents' records. Relatives interviewed stated they were well informed upon admission. The service has an information pack available for residents/family and at entry. The admission agreement reviewed aligns with the service's contracts. Ten admission agreements viewed were all signed. 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>	<p>FA</p>	<p>The service has a policy that describes guidelines for death, discharge, transfer, documentation and follow up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Low</p>	<p>There are policies and procedures in place for all aspects of medication management, including self-administration. All medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. All medications are appropriately stored in a secure environment</p> <p>Registered nurses, enrolled nurse and senior caregivers responsible for the administering of medications have completed annual medication competencies and annual medication education. There were two self-medicating rest home level residents on the day of audit. Self-medicating competency, three monthly reviews and monitoring were in place. The medication fridge has temperatures recorded daily and these are within acceptable ranges.</p> <p>Twenty medication charts were reviewed (ten rest home and ten hospital). Photo identification and allergy status was on all charts. All medication charts had been reviewed by the GP at least three monthly. All resident medication administration-signing sheets corresponded with the medication chart. A shortfall was identified around the prescribing of warfarin and storage of medication keys.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service</p>	<p>FA</p>	<p>Mayfair Lifecare has a well-run food service that is managed by a head cook and supported by part-time cooks and kitchen hands. All are trained in food safety. A four week winter and summer menu is reviewed by a dietitian and regular food safety compliance audits are conducted. Residents and families interviewed were complimentary of the food provided. The service is able to meet the dietary and food service requirements of rest home and</p>

<p>is a component of service delivery.</p>		<p>hospital level residents.</p> <p>Nutritional assessments had been conducted in all ten resident files reviewed. Dietary information is documented in the care plan and a dietary form is provided for kitchen staff.</p> <p>The service is able to respond to residents with additional or modified dietary requirements. Special equipment and utensils for residents who require assistance is available. Staff are available to assist residents with food and fluid intake.</p> <p>Resident's weight is monitored regularly. Those residents with weight issues have a short-term care plan in place. There is evidence of residents receiving supplements and the clinical nurse manager advised that a dietitian is available for advice and support if required.</p> <p>Daily temperature checks of fridge and freezer are maintained as well as hot and cold food temperatures. The walk-in chiller, freezer and pantry are clean and tidy with no food stored on the floor. Food is covered, labelled and dated. The food programme at Mayfair incorporates infection control and health and safety information and guidelines.</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>	<p>FA</p>	<p>The service records the reasons for declining service entry to residents should this occur and communicates this to the resident and family. Potential residents would be referred back to the referring agency if entry were declined.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>The facility has embedded the interRAI assessment protocols within its current documentation. Paper based assessments were undertaken on admission to services and an initial care plan completed for all the resident files reviewed. InterRAI initial assessments and assessment summaries were evident in printed format in all long-term files. Files reviewed across the rest home and hospital identified that care plans had been reviewed six monthly as part of the evaluation. Additional assessments for management of behaviour, wound care (link 1.3.6.1) and restraint were completed according to need.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are</p>	<p>PA Low</p>	<p>Resident care plans sampled were personalised, however care plans did not always document the specific care interventions required to meet all current needs. Residents and family members interviewed confirm they are involved in the development and review of care</p>

<p>consumer focused, integrated, and promote continuity of service delivery.</p>		<p>plans. Short-term care plans were in use for changes in health status and were evaluated on a regular basis and signed off as resolved or transferred to the long-term care plan. There was evidence of service integration with documented input from a range of specialists.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Moderate</p>	<p>Care plans are documented for all residents. When a resident's condition changes, the RN initiates a GP visit or nursing specialist referral. Residents interviewed reported their needs were being met. Family members interviewed stated the care and support met their expectations for their relative. There was documented evidence of relative contact for any changes to resident health status.</p> <p>Continence products are available and resident files include interventions for continence needs and continence products as needed. Specialist continence advice is available as needed and this could be described by the RNs interviewed. Caregivers and RNs interviewed state there is adequate continence and wound care supplies.</p> <p>Wound assessment, wound management, evaluation forms and short-term care plans were in place for all minor wounds (ten skin tears, one scratch, one chronic ulcer, one necrotic toe and one other wound). There were four pressure injuries (three hospital and one rest home). Not all wound documentation was fully completed.</p> <p>Monitoring charts were in use and examples sighted included (but not limited to), weight and vital signs, blood glucose, pain, food and fluid, turning charts and behaviour monitoring as required. There was no documented evidence that monitoring was occurring for restraint. During the audit it was observed that not all residents were able to reach a call bell.</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>	<p>FA</p>	<p>The service employs two diversional therapists who provide activities Monday to Friday for 37.5 hours per week.</p> <p>A large purpose-built room (the Gallery) is available for activities to take place and is well equipped. There is a resident social profile and activity assessment completed and an activity plan is developed and reviewed at least three monthly. The facility activity plan is developed on a monthly basis with input from residents. A variety of activities are provided that also reflect normal patterns of life. The programme is monitored through regular meetings and surveys. A record of attendance is kept and progress notes written. Residents and families interviewed indicated they found the programme enjoyable and interesting.</p> <p>Residents are encouraged to maintain links with the community with visits from external groups and trip out into the community. There are regular entertainers to the home and</p>

		<p>residents go on regular outings and drives.</p> <p>Residents/family interview praised the activities provided for residents.</p> <p>In 2015 the service implemented a quality project: 'Moving with meaning' (exercise with a smile) commenced 2015. The project included key goals and an action plan. Effectiveness of this programme is planned for evaluation this month.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Care plans reviewed had been evaluated by registered nurses' at least six monthly. One rest home and one hospital resident had not been at the service six months. Written evaluations describe the resident's progress against the resident's identified goals. InterRAI assessments have been utilised in conjunction with the six monthly reviews. Short-term care plans for short term needs were evaluated and either resolved or added to the long-term care plan as an ongoing problem. There is at least a three monthly review by the medical practitioner. The family members interviewed confirmed involvement in care plan reviews and are informed regarding GP visits.</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 sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where a resident's condition had changed and the resident was reassessed for a higher or different level of care.</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>There are policies and procedures in place for waste management. Residents, staff and visitors are protected from harm through safe practice. There is an approved system in place for the safe disposal of sharps. Chemicals are labelled with manufacturer labels. There are designated areas for storage of chemicals and chemicals are stored securely. Laundry and sluice rooms are locked when not in use. Product use information is available. Protective equipment including gloves, aprons and goggles are available for use by staff. Staff interviewed were familiar with accepted waste management principles and practice.</p>
<p>Standard 1.4.2: Facility Specifications</p>	FA	<p>The service displays a current building warrant of fitness, which expires on 1 August 2016.</p>

<p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>The maintenance person completes annual scheduled maintenance and is informed by staff of issues that require attention. Hot water temperatures checks are conducted monthly and are at 45 degrees' maximum in resident areas. Medical equipment including scales and hoists have been checked and calibrated annually. Electrical equipment has been tested.</p> <p>There is a small internal seating area at the entrance available for residents and visitors. Residents were observed safely mobilising throughout the facility. There is easy access to the outdoors. The exterior by the entrance is well maintained with safe paving, outdoor shaded seating, lawn, gardens and car parking. Interviews with the registered nurses and the caregivers confirmed that there was adequate equipment to carry out the cares according to the resident's care plans.</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>Resident rooms have a minimum of a hand basin and toilet ensuite facilities. Some rooms have full ensuite facilities. There are sufficient communal showers for the resident numbers. There are large communal lounge and dining areas. The number of visitor and resident communal toilets provided is adequate. Hand washing and drying facilities are located adjacent to the toilets. Liquid soap and paper towels are available in all toilets. Fixtures, fittings, floor and wall surfaces are made of accepted materials to support good hygiene and infection prevention and control practices. The communal toilets and showers are well signed and identifiable and include vacant/engaged and in-use signs.</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>The rooms are spacious enough to meet the assessed needs of residents. Residents are able to manoeuvre mobility aids around their bed and personal space areas. All hospital residents have electric beds. Caregivers interviewed report that rooms have sufficient room to allow cares to take place. Bedrooms are personalised.</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 are two large lounges and two dining rooms. A large gallery room is used for activities, recreation and dining activities. The rest home/hospital dining room is spacious and located directly off the kitchen/servy area. All areas are easily accessible for residents. The furnishings and seating are appropriate. Residents were seen to be moving freely both with and without assistance throughout the audit. Residents interviewed report they can move around the facility and staff assist them if required.</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 are documented systems for monitoring the effectiveness and compliance with the service's policies and procedures. There is a separate laundry area where all linen and personal clothing is laundered by the designated laundry staff. Staff attend infection prevention and control education and there is appropriate protective clothing available. Cleaners are employed seven days a week. Manufacturer's safety data charts are available for reference if needed in an emergency. Residents and family interviewed report satisfaction with the laundry service and cleanliness of the facility.</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 service has a fire and emergency procedures manual. The evacuation scheme was approved by New Zealand Fire Service on 1 July 1997. Fire drills are conducted six monthly. There is at least one staff member with a first aid certificate on each shift. Fire safety training has been provided. There is an electronic call bell system in place. A civil defence kit is stocked and checked monthly. Water is stored, sufficient for at least three days. Alternative heating and cooking facilities are available. Emergency lighting is installed. Staff and a contracted firm conduct checks of the building in the evenings to ensure the facility is safe and secure. There are emergency management plans in place to ensure health, civil defence and other emergencies are included.</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>All communal and resident bedrooms have external windows with plenty of natural sunlight. The facility is heated by an underfloor heating system. The general living areas and resident rooms were appropriately heated and ventilated on the day of audit. Residents and family interviewed state the environment is comfortable.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The clinical manager (RN) is the infection control coordinator and is responsible for infection control across the facility. The Arvida infection control nurse has developed the IC policies and procedures and provides support to the clinical manager. Mayfair Lifecare engages an external quality advisor two days a week for further risk management support.</p> <p>Infection control nurse specialist at the DHB provides further advice and support. The infection control committee is linked to the health and safety committee and consists of a</p>

		cross-section of staff. The programme has been reviewed annually.
<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>There are adequate resources to implement the infection control programme. The infection control team is linked to the health and safety committee and reports to the quality committee. The quality committee reviews IC statistics monthly and compares against service KPIs. Action plans are implemented when the service is outside set parameters. External resources and support are available as required as well as an Arvada IC specialist. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</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 infection control manual outlines a comprehensive range of policies, standards and guidelines and defines roles, responsibilities and oversight, the infection control team, training and education of staff and scope of the programme.</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>Mayfair has robust infection control policies and procedures. All staff receives education at orientation on all aspects of infection control relevant to their position. Priority for all staff is given to hand hygiene, use of PPE, waste management and standard precautions in everyday practice. Mayfair includes infection control education in its annual education plan. All staff are assessed at least annually on their hand hygiene technique.</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</p>	CI	<p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility.</p> <p>Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the general practitioners. Systems in place are appropriate to the</p>

programme.		<p>size and complexity of the facility.</p> <p>Effective monitoring is the responsibility of the infection control coordinator. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. Surveillance data is available to all staff.</p> <p>Infections statistics are included for benchmarking. Corrective actions are established where trends are identified.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Mayfair has a philosophy to aim for a restraint-free environment. The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. The policy includes comprehensive restraint procedures. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. The restraint standards are being implemented and implementation is reviewed through care plans and care plan reviews, internal audits, monthly clinical and quality meetings and three monthly GP reviews. Interviews with the staff confirm their understanding of restraints and enablers.</p> <p>Enablers are assessed as required for maintaining safety and independence and are used voluntarily by the residents. On the day of audit, the service had four residents using restraint in the form of bedrails and no current enablers. Training around restraint use, enablers and challenging behaviours has been provided as part of the service annual training plan.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>The clinical manager is the restraint coordinator and reports to the quality team on a monthly basis. The restraint approval process and the conditions of restraint use are recorded on the restraint assessment form. Assessments are undertaken by suitably qualified and skilled staff such as the RN and GP in partnership with the resident and their family/whānau.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where</p>	FA	<p>The service completes a consent form and an assessment for residents who require restraint or enabler intervention. Assessments are undertaken by the RN in partnership with the family. The restraint assessment form is completed with input from the RN, GP and the resident's family. There were four residents with bedrail restraint. Two resident files reviewed</p>

indicated, in relation to use of restraint.		for residents with restraint both had completed consent forms and assessments in place.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The restraint policy requires that restraint is only put in place where it is clinically indicated. The assessment for restraint includes exploring alternatives, other needs and behaviours. Two files were reviewed for the residents with restraint and alternative were documented as considered (link to 1.3.6.1). The restraint register is in place and is up to date (link to 1.3.5.2).
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The use of restraint is evaluated and reviewed as part of the three monthly GP review and monthly quality meetings. An annual review of all restraints is also documented.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The review of restraint is embedded into the quality process at Mayfair. There are annual restraint audits (documented May 2015) and an annual review of restraint use. Monthly quality meetings also discuss restraint and its use.

## 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 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	PA Low	<p>Following review of resident incidents and accidents and associated resident files, current pressure injuries were identified as not having being reported via the incident reporting process. The incident and accident forms reviewed included falls, skin tears, bruising and challenging behaviours and one pressure injury, which has now healed.</p>	<p>Four pressure injuries currently being treated have not been reported via the incident reporting process.</p>	<p>Ensure that all pressure injuries are reported via the incident reporting process.</p> <p>60 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management</p>	PA Low	<p>Nineteen of twenty medication charts reviewed met legislative requirement. Discontinued</p>	<p>(i)One resident on warfarin did not have the variable medication dose signed by the prescriber; and (ii) on the day of audit it was observed that medication keys</p>	<p>(i)Ensure all medication orders are signed by an authorised prescriber;</p>

system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.		medications were dated and signed by the GP. All 'as required' medications had an indication for use.	were not kept with an RN and were left in an office that was not always kept locked.	and (ii) ensure that the medication keys are always stored appropriately and securely.  30 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 Low	All resident files reviewed had a care plan in place. Activities of daily living, skin care and nutrition were documented well in all care plans reviewed across the rest home and hospital. One resident with end of life care had a holistic care plan in place. Caregivers interviewed were able to describe the current care needs of the residents well. Care plan interventions for rest home residents described the care and support required. Shortfalls were identified in the hospital care plans reviewed.	Care plan interventions for the following hospital residents did not fully describe the care and support needed: (i) two care plans for residents with behaviours that challenge did not document the interventions needed to manage behaviours; (ii) two hospital level residents with identified pain did not have pain management interventions documented in the care plan (noting analgesia was documented and administered); (iii) risks associated with restraint use were not documented for two hospital level residents with restraint; (iv) three hospital resident care plans did not have the current mobility status documented; and (v) one hospital resident on insulin did not have the recognition and management of hypoglycaemia documented.	Ensure that interventions in the care plan reflect the resident's current needs as identified through assessment and progress notes.  60 days
Criterion 1.3.6.1 The provision of services and/or	PA Moderate	Discussion with caregivers and RNs evidenced that care staff were well acquainted with the care needs of the residents. Relatives	(i) Restraint monitoring was not documented for two hospital level residents; however this could be described by staff; (ii) two residents, who were unable to self-mobilise, were not able to reach their	(i) Ensure documentation reflects that residents are monitored as directed in the care plan; (ii) ensure

<p>interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>		<p>and resident interviewed stated that care and support provided is of a high standard. The GP interviewed stated he was happy with the clinical care provided. Not all documentation is completed as required.</p>	<p>call bells (addressed during audit); (iii) one wound care assessment and plan did not identify the wound type and one wound assessment and plan included management of three different wounds. (iv) wound dressings are completed by the senior caregivers (RN assistants). Wound care reviews were only referred to an RN if the registered nurse assistant considered that the dressing needed review.</p>	<p>call bells are in reach; (iii) ensure wound care assessments identify where the wound is, the type of wound and an assessment/management plan is completed per wound: (iv) ensure RNs are involved in the assessment and management of wounds.</p> <p>30 days</p>
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 3.5.7</p> <p>Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>	CI	<p>Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. 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 the quality improvement meetings and staff meetings.</p>	<p>The service has undertaken a number of initiatives as a result of infection surveillance data to reduce infection numbers. Analysis of infection data occurs monthly and includes opportunities for improvement. Quarterly reports are also completed from benchmarking analysis. Monthly infection surveillance includes whether resolved, trends and quality initiatives. The service implemented a quality project in 2015 around reducing UTIs by 50% over a six month period. This was implemented as a result of UTIs being above the benchmark in both the rest home and hospital. Actions were implemented around driving staff awareness on the direct relationship between practice and infection risk, review of PPE, increase monitoring of hand hygiene practices by way of ‘spot’ audit and improve fluid nutrition intake for high risk residents. Evaluation identified reduction in hospital residents, change in strategies for rest home residents with dementia and reduction noted Oct – Dec 2015.</p>

End of the report.