

Heritage Lifecare (BPA) Limited - Maxwell Care Home

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity: Heritage Lifecare (BPA) Limited

Premises audited: Maxwell Care Home

Services audited: Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric)

Dates of audit: Start date: 23 January 2018 End date: 24 January 2018

Proposed changes to current services (if any): Heritage Lifecare Limited has purchased the Maxwell Care Home from Bupa resulting in this provisional audit.

Total beds occupied across all premises included in the audit on the first day of the audit: 20

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.

General overview of the audit

Maxwell Care Home provides rest home and hospital level care for up to 25 residents. The service is currently operated by Bupa New Zealand, although a sale and purchase agreement with Heritage Lifecare Limited is in place. It is managed by a facility manager and a clinical services manager who relieve for one another when required. Residents and families spoke positively about the care provided.

This provisional audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board, in preparation for Heritage Lifecare Limited taking over management of the Maxwell Care Home. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, management, staff, and a general practitioner.

This audit has identified six areas for improvement relating to the care and care plan of a more complex resident, activity time for residents, care plan evaluations and reviews, a dietitian's review of the menu, the infection control programme and infection control education.

Consumer rights

Copies of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) are provided to residents on admission and are on display. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

The different aspects of the Code, including respecting personal choices, privacy, independence, individual needs and the dignity of residents are being upheld during service delivery. Staff were consistently noted to be interacting with residents in a respectful manner.

Although there are not currently any residents who identify as Māori, a Māori health plan and related cultural policies are available. There was no evidence of abuse, neglect or discrimination and professional boundaries are maintained.

Open communication between staff, residents and families is promoted, and confirmed to be effective. Access to formal interpreter services is available and there is an awareness of effectively communicating with residents who have disabilities related to communication.

Visitors are welcome and the service has strong linkages with a range of specialist health care providers and support services.

A complaints register is maintained with complaints resolved promptly and effectively.

Organisational management

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

Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people.

Continuum of service delivery

Information about the facility and the services provided is readily available from the service provider and from the local Needs Assessment and Service Co-ordination Service, with which the Maxwell Care Home has close relationships.

Residents' needs are assessed by the multidisciplinary team on admission within the required timeframes. Registered nurses are on duty 24 hours each day in the facility and are supported by care and allied health staff such as a podiatrist, a contracted physiotherapist and pharmacists. A designated general practitioner attends to residents, although residents may continue with their own. On call arrangements for support from senior staff are in place. Shift handovers and comprehensive progress notes guide continuity of care.

Care plans are individualised. They are based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. All residents' files reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and

involved in care planning and evaluation, and that the care provided is of a high standard. When required, residents are referred or transferred to other health services, with appropriate verbal and written handovers.

A planned activity programme, which is overseen by a diversional therapist, provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings.

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

The food service meets the nutritional needs of the residents with special needs catered for. A food safety plan and related policies guide food service delivery. Kitchen staff have food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents verified satisfaction with meals.

Safe and appropriate environment

The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells. Security is maintained.

Restraint minimisation and safe practice

The facility has implemented policies and procedures that support the minimisation of restraint. Two enablers and two restraints were in use at the time of audit. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

An infection prevention and control programme is being implemented according to organisational infection prevention and control policies and procedures. Implementation of the programme, including staff education, internal audits and the infection surveillance, is overseen by an infection control coordinator. Specialist infection prevention and control advice and resources are readily available.

Staff demonstrated good principles and practice around infection control, which are guided by relevant policies and supported with regular education. Aged care specific infection surveillance is undertaken with results reported through all levels of the organisation. Corrective actions are identified when relevant.

The new provider has an established infection prevention and control programme ready for integration into current practices.

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	44	0	5	1	0	0
Criteria	0	95	0	4	2	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Maxwell Care Home has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code).</p> <p>Training on the Code is included as part of the orientation process for all new staff employed and in ongoing training, as was verified in training records. Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, providing options and maintaining dignity.</p> <p>Residents and relatives who were interviewed, and who understood the Code, confirmed that the principles of the Code are upheld.</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>There are informed consent policies and procedures. An overall consent form that includes the storage and release of the resident's information, one for van outings and one for the taking and use of photographs are in use. Signed copies of these forms were in all residents' files reviewed, as relevant. The forms provide an overview of the context and purpose</p>

		<p>of the consent.</p> <p>Registered nurses demonstrated their understanding of the consent processes by explaining how they obtain the signatures, who from, and under what circumstances. Staff were observed to gain verbal consent on an informal basis during day to day cares. Residents confirmed this is usual practise for both registered nurses and care staff.</p> <p>Residents' files reviewed included completed Enduring Power of Attorney (EPOA) documentation and where resident are unable to give their own consent the EPOA is being contacted as required. Only two of the residents' files reviewed included evidence of advance care planning, or decision making, which staff attributed to the level of disability that residents were experiencing on admission. Copies of completed and signed forms regarding for the EPOA and the resuscitation status for each person were sighted in all files reviewed.</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>	<p>FA</p>	<p>Residents are given a copy of the information brochure on the Advocacy Service during the admission process. Posters related to the Advocacy Service were also displayed in the facility, and additional brochures were available at reception. Family members spoken with were aware of the Advocacy Service and of where the information about it is. Residents know of their right to have support persons whenever they want and some choose to have family members present during medical and/or multi-disciplinary reviews.</p> <p>Staff interviewed knew about the Advocacy Service. The manager informed of an example of the involvement of an external advocate that had been accessed for one of the residents.</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>	<p>FA</p>	<p>Staff described ways in which they assist residents to maintain contact with their families and vice versa. Family members who assist with feeding and other aspects of personal care said they are always welcomed by staff and they know their input is appreciated by staff, as well as their family member. Residents are assisted to maximise their potential for self-help as they are able, and to maintain links with their family and the community by attending a variety of van trips, for trips,</p>

		<p>activities, and entertainment. The facility has unrestricted visiting hours and encourages visits from residents' family and friends.</p> <p>Other community organisations that residents have links to are the local churches and organisations such as the district nursing service, the local palliative care team, Alzheimer's Society and Aged Concern, who the manager said they may contact for expertise, advice and information.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints and concerns policy and the associated documents meet the requirements of the Code. There is a flowchart associated with the policy to assist staff in understanding the process for complaints management. Residents and their families receive information on the complaints process in the welcome pack on enquiry and again on admission. These packs include a pamphlet of the Code. Pamphlets are available, and posters are displayed, throughout the facility.</p> <p>The complaints register reviewed showed that there had been five complaints over the last year, and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans show any required follow up and improvements have been made where possible. The facility manager in conjunction with the clinical manager is responsible for complaints management and follow-up for complaints of a moderate severity rating. The operations and quality and risk managers are responsible for complaints with a higher risk rating and they allocate actions to the facility manager and/or clinical manager as required. All staff interviewed confirmed a sound understanding of the complaints process and what actions are required. There have been no complaints from external sources since the last audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>The clinical manager explained that residents and relatives are informed about the Code when new residents are admitted into the Maxwell Care Home. Sample enquiry and admission packages all had information on how to make a complaint as well as copies of brochures of the Code in them.</p> <p>Although residents were unsure about the details of the Code, relatives</p>

		<p>confirmed during interview that such information had been provided. Residents stated they are treated with respect, are given options and have no issues of concern.</p> <p>Information about the Nationwide Health and Disability Advocacy Service (Advocacy Service) is also a component of the admission package provided. The Code, with information about the Advocacy service at the bottom, is displayed in both English and te reo Maori in two areas of the facility. Copies of the brochures on the Code and the Advocacy Service were in a holder in the reception area, along with copies of complaint and feedback forms.</p> <p>The prospective provider is an experienced aged care sector provider, therefore has a good knowledge of the Code. Existing clinical staff are transitioning to the new provider following the sale and they have a good understanding of the requirements of the Code as part of their existing roles.</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>	<p>FA</p>	<p>There is a policy as well as guidelines on privacy and dignity. Residents and family members confirmed that services are being provided in a manner that has regard for residents' dignity, spirituality and preferences. Staff explained that most residents are no longer able to be independent in many aspects of their life but are encouraged to make their own decisions for as long as they are able. Privacy is maintained during the delivery of personal care, resident information is held securely and staff were conscious about not undertaking conversations about residents in public areas.</p> <p>All residents have a private room. Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and as far as possible incorporated into their care plan. On-site interdenominational church services are organised monthly.</p> <p>Staff interviewed understood the service's policy and procedures on abuse and neglect, which are appropriate and give good guidance to staff members. Staff records demonstrated that education on abuse and neglect is part of the orientation programme for staff, and is a component of the annual staff training programme. Residents and</p>

		relatives informed they had not experienced, nor seen, any staff behaviours that were suggestive of abuse or neglect.
<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>A current document and set of flip charts on 'Tikanga' describes best practice guidelines for Maori health. The clinical manager and wider staff group informed that there are not currently any residents who identify as Maori. The manager is closely associated with local iwi and described how education about the principles of the Treaty of Waitangi are provided to the staff, as is the importance of whānau for Māori residents. Current access to resources includes the contact details of local cultural advisers at one of the marae. There are not currently any residents in the Maxwell Care Home who identify as Maori.</p> <p>Heritage Lifecare has a policy on Maori health plan consultation intended to guide the facility on developing their own Maori Health plan. This document serves as a template for the plan. It includes making contact with the local DHB, Maori health providers, kaumatua and kuia at the local marae and an advocacy groups as is necessary to support residents who identify as Maori in the facility. There is a Maori health plan consultation template with questions to ask each Maori resident so that any barriers which are within the facility's control can be identified.</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>Residents and relatives verified that they were consulted on their individual culture, values and beliefs and that staff respect these. Such information is collected on admission as part of the admission assessment process.</p> <p>Resident's personal preferences, required interventions and special needs were included in all care plans reviewed. Meal preferences, the time they get up or go to bed, the people they sit beside or near and their level of participation in daily activities, for example, are all respected. Activity records show that the activities coordinator pays attention to individual cultural needs with additional one on one activities.</p> <p>Staff described how well they get to know the residents and their families and how this enables them to better understand and follow</p>

		through with individual values and beliefs.
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Residents interviewed could not think of any instance in which they had experienced, or witnessed, any form of discrimination, harassment or exploitation and all said they felt safe. A general practitioner also expressed satisfaction with the standard of services provided to residents. Family members spoken with were fully satisfied that no such actions were occurring.</p> <p>Policies and procedures that reflect the service provider's non-acceptance of any form of exploitation, discrimination or harassment for residents, and for staff, are in place. Copies of a Code of Conduct for staff were viewed and position descriptions sighted further described the service provider's expectations of them. Staff orientation and ongoing education includes information on professional boundaries and expected behaviours. The manager noted there is a zero tolerance for any form of exploitation, discrimination or harassment.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The current service provider encourages and promotes good practice through the use of experienced and knowledgeable staff at the organisational level of Bupa NZ where formats of care plans, policy and procedure documentation and best practice are determined. Registered nurses maintain their professional development to ensure good practice is implemented and executed. Use of external specialist services and allied health professionals, such as district nurses, the hospice/palliative care team, a physiotherapist, services for older people and mental health services for older persons complement the employed staff to ensure the best level of care possible is provided. The general practitioner (GP) confirmed the service seeks prompt and appropriate medical intervention and advice when required.</p> <p>Other examples of good practice that were identified by the manager and/or observed during the audit were that staff have good working relationships, operate as a team and willingly assist one another. There are open relationships between caregivers and the registered nurses, solution finding approaches are taken to identified concerns; transparent</p>

		communication processes with families were evident and staff are delegated duties according to their individual strengths.
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Residents and family members stated they were kept well informed about any changes to their/their relative's status. Information is reportedly being made in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in the well maintained communication logs in residents' records reviewed. There was good evidence in residents' files of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Current policies and procedures enable access to interpreter services and the new provider is implementing an information, communication and language policy, which includes the provision of interpreter services. In the first instance families will be used to interpret for the resident. If they are not available then appropriate interpreter services will be accessed and/or information will be provided in other formats. The clinical manager, nor other longer term staff, could recall any prior need for interpreter services.</p> <p>Observations and interviews confirmed that staff are ensuring hearing aids are in place and people requiring spectacles for a visual impairment are having these needs attended to.</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>	FA	<p>The scope, direction, goals, values and mission statement of the organisation are communicated throughout the facility in a variety of ways including within job descriptions, at orientation and on posters. Monitoring of the services provided to the governing body is regular and effective. There is a standard template for the business plan which has been used by the facility to develop site specific objectives, which link to the organisation's quality plan objectives. Two are organisation objectives and two are facility specific.</p> <p>The facility manager reports to an operation's manager on a weekly and a monthly basis. The weekly report includes occupancy, general</p>

	<p>comments on movements, health and safety and compliance issues (incidents/accidents), new risks identified, and any outstanding issues. The organisation's quality and compliance manager transfers these items to the organisation's risk register and / or updates the register. Compliments and complaints, staffing and HR issues including training, property and environment issues and general comments are included in reporting. There is a weekly operations meeting on Monday mornings to review the weekly reports and discuss any issues. A sample of weekly and monthly reports to the operation manager showed adequate information to monitor performance is reported including contractual and financial performance, emerging risks and issues.</p> <p>The service is managed by a facility manager who holds relevant qualifications, is experienced, has been in the role for six months and is supported by a clinical manager who is a registered nurse with 15 years' experience. Responsibilities for both these managers are defined in job descriptions and individual employment agreements. The facility manager confirms knowledge of the sector, regulatory and reporting requirements and maintains currency through the BUPA managers' forum and updates.</p> <p>The service holds contracts with ACC, MOH, DHB and has private payers. No residents were receiving services under an ACC contract at the time of audit.</p> <p>New Provider Interview January 2018: The new provider (Heritage Lifecare Ltd – HHL) is an established New Zealand aged care provider, currently operating more than 1100 beds in the sector. This proposed acquisition is part of an acquisition that will add a further twelve facilities across the country. An organisational structure document sighted details the reporting lines to the board currently in place (as at 30 November 2017). As of 30 January 2018 HLL has set up a new company to acquire and operate this group of new facilities. This company is Heritage Lifecare (BPA) Ltd. However for ease of reference the new provider is referred to as Heritage Lifecare Limited (HLL) throughout this report.</p> <p>The transition plan is led by an experienced and well-qualified project team who are specifically focussing on the integration of the current facilities into the Heritage Lifecare Ltd group. This includes provision of infrastructure support such as providing information technology</p>
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		<p>capability including hardware and software. Regional workshops are planned to introduce documentation, and the new HHL systems and processes. This is planned to occur within the first three months. The project team is working with the BUPA team to ensure a smooth transition of each operation.</p> <p>It is expected that the senior team will remain in place at each facility and that existing staff will transfer to the new provider. The prospective purchaser has notified the relevant District Health Board prior to the provisional audit(s) being undertaken.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>When the facility manager is absent, the clinical manager carries out the required duties under delegated authority. During absences of the clinical manager, clinical management is overseen by the 'registered nurse lead' on duty who is experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported that the current arrangements work well.</p> <p>New Provider Interview January 2018: The prospective provider is not planning any staff changes. Existing cover arrangements for the day to day operations will remain in place, with access to regional operations managers. The prospective new owner understands the needs of the different certified service types and understands the Age Residential Related Care (ARRC) agreement, including in relation to responsibilities of the ARRC manager to meet section D17 of the agreement.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular patient satisfaction survey, monitoring of outcomes, clinical incidents including infections and restraint use.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the infection control, health and safety, quality and risk, restraint and staff meetings. Staff reported their involvement in quality and risk management activities through audit activities, corrective action</p>

		<p>implementation and adverse events reporting. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The facility manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager has been provided with education as part of orientation on the Health and Safety at Work Act (2015) and the organisation implemented requirements.</p> <p>New Provider Interview January 2018: During the transition phase, HLL policies and procedures will be introduced. By the end of 2018, a new software system will be introduced to incorporate risk management including adverse event reporting, care planning and client management. Meanwhile, the electronic BUPA system will be superseded by HLL documentation and will be reliant on hard copies on site until the electronic system is fully implemented. This is anticipated to be within six months of the purchase.</p> <p>HLL has a generic annual quality plan in place which outlines goals and objectives for the coming year. Each site personalises this to their own facility. The plan includes internal audits and improvement activities and projects. The HLL quality plan will be introduced to managers at the proposed regional study days to occur during the transition period. Reporting against the quality plan occurs monthly through the operational management structure. A key strategy to introduce a national clinical governance group is planned in the next 12 months.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically</p>	<p>FA</p>	<p>Staff document adverse and near miss events on an accident/incident form or within the electronic system. A sample of incidents reviewed showed these were fully completed, incidents were investigated, action</p>

<p>recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported within the electronic system to head office managers.</p> <p>The facility manager described essential notification reporting requirements, including for pressure injuries. They advised there have been no notifications of significant events made to the Ministry of Health, since the previous audit.</p> <p>New Provider Interview January 2018: There are no known legislative or compliance issues impacting on the service. The prospective owner is aware of all current health and safety legislative requirements and the need to comply with these. The national quality manager interviewed was able to verbalise knowledge and understanding of actions to meet legislative and DHB contractual requirements.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and annual practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation and a performance review after a three-month period.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. A staff member is the internal assessor for the programme. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</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>	<p>FA</p>	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate and there is 24//7 RN coverage in the facility.</p> <p>New Provider Interview January 2018: The prospective owner intends to maintain the current staffing levels and skill mix. HLL has a documented policy based on the Guidelines for safe staffing level and indicators. The representative for HLL interviewed confirmed understanding of the required skill mix. The organisation already provides the range of levels of care (geriatric/medical, dementia, rest home and psychogeriatric services) and recognises the competencies and contractual obligations to be met when delivering these services.</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>	<p>FA</p>	<p>Personalised labels, which include the resident's name, date of birth and National Health Index (NHI) number were on all pages of residents' information sighted. In the sample reviewed, residents' records detail the necessary demographic, personal, clinical and health information. Clinical notes were current and integrated with GP and allied health service provider notes. Electronic based, interRAI assessment information was up to date and used to contribute to care planning. Records, including progress reports, were legible with the name and designation of the person making the entry identifiable.</p> <p>All residents' records were stored in lockable areas not publicly accessible. Archived records on site were held securely and were retrievable. These are later transferred to a national archive store for secure storage for the required period before being destroyed. Electronically recorded information is password protected.</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>Organisational policies and procedures describe the entry processes into the Maxwell Care Home and clearly state that it is an aged care facility that provides rest home and hospital level care. Residents are required to have had a needs assessment undertaken by the local Needs Assessment and Service Coordination (NASC) Service before entry. Prospective residents and/or their families are encouraged to visit the facility prior to admission and meet with the facility manager and the reception person in the facility manager's absence. Written information about the service and the admission process is provided and copies of example packages were viewed. There is not currently a waiting list as there are no empty beds.</p> <p>Family members and residents stated during interview that they were satisfied with the admission process. They confirmed that the information made available prior to and on admission was clear and adequate. All residents' documentation reviewed was in accordance with contractual requirements. Signed admission agreements, financial papers, NASC assessments and EPOA documents were in residents' files stored in locked cabinets that are overseen by the reception person. Documents such as EPOA documents and demographic details are copied and placed in residents' service delivery files.</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>Policies and procedures for the management of exit, discharge or transfer processes were viewed and are aimed at reducing risks associated with these processes. Such processes are managed in a planned and co-ordinated manner. The clinical manager informed that to date there have been no incidents/accident forms completed as a result of risks associated with residents moving between facilities, or hospital services.</p> <p>The service provider uses the DHB's 'yellow envelope' system to facilitate the transfer of residents to and from acute care services. This enables relevant documentation to accompany the resident. Managers and staff described the open communication that occurs between all services, the resident and the family.</p>

		<p>The clinical manager explained that because the Maxwell Care Home provides hospital level care, few people leave the facility to go elsewhere, unless for a temporary acute care episode to the local hospital. If a person is transferring to a different facility, then one of the registered nurses or a family member accompanies the person and a verbal handover is provided. Ongoing relationships are reportedly kept open to ensure continuity of care.</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>FA</p>	<p>The medication management policy and procedures identify all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care and relevant legislation.</p> <p>Maxwell Care uses the One Chart electronic medicine management system, which staff report has dramatically reduced the incidence of medicine errors. A medicine round was observed on the day of audit and practices were safe. The staff person involved demonstrated good knowledge of the processes and had a clear understanding of their roles and responsibilities related to each stage of medicine management. Records sighted confirmed that all staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged robotic packaging from a contracted pharmacy. These medications are checked by a registered nurse against the prescription and are signed as correct when they enter the facility. All medications sighted that were checked were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements. Two staff check each administered controlled medicine for accuracy and stocks are also checked weekly by two staff with a relevant medicine competency. Evidence of the accuracy of these checks was confirmed in the controlled drug register.</p> <p>Daily records of temperatures for the medicine fridge were within the recommended range.</p> <p>The use of One Chart is enabling good prescribing practices to be maintained signature. The date of commencement, discontinuation and</p>

		<p>review of medicines is evident and all requirements for pro re nata (PRN) medicines are met.</p> <p>There are not currently any residents who self-administer medications at the time of audit. Appropriate processes are in place to ensure such actions are managed in a safe manner should a person choose to self-administer their medicines and be assessed as competent to do so.</p> <p>Medication errors are reported on an accident/incident form and followed through as per the usual incident/accident investigation processes. The resident and/or the designated representative are advised.</p> <p>Standing orders are not used in this facility and with the use of One Chart verbal orders are no longer taken.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>PA Low</p>	<p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and efforts to accommodate these are made in the daily meal plan. Records of individual requirements were sighted in a folder and on a white board in the kitchen. Special equipment that meets residents' nutritional needs is available when required.</p> <p>The food service is provided on site by a cook and kitchen team. The menu that was reviewed by a registered dietitian just over two years ago rotates on a four weekly basis with summer and winter variations. An email from Bupa NZ confirming the menu is currently under review was sighted. However, the new provider Heritage Lifecare advised they have their own menu, which is already dietitian approved and will be introduced over time. During an interview with the cook it became evident that it is not always possible to cook the designated food on the menu due to the large number of meals that need to be of a soft or puree consistency. Efforts to accommodate the needs of these people were described; however, it was also evident that with these deviations from the menu it was no longer possible to confirm that the food being provided is necessarily consistent with the nutritional requirements of</p>

		<p>the residents.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Documents for the food safety plan registration dated 2017 were sighted. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The food service manager has undertaken a safe food handling qualification and is scheduled for another in 2017. Kitchen assistants have completed relevant food handling training.</p> <p>There were no complaints about the meals when residents and family members were specifically asked during interviews. Four people commented on the extra lengths the cook goes to that ensures residents with chewing and/or swallowing difficulties or personal dislikes have their needs and preferences met. Observations made during the audit demonstrated that staff work together to ensure that the needs of the large number of people requiring assistance with feeding have their needs met. Family members were observed assisting in the dining room and those spoken with said they try to assist where possible. Staff demonstrated their awareness of food temperatures and on the regulations for reheating food.</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>If a referral is received but the prospective resident does not meet the entry criteria, or there is no vacancy at that time, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative.</p> <p>Should the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is completed and in consultation with the resident and their whānau/family, a new placement is found. Examples of this occurring were discussed with the facility manager, who to date has not had to decline entry to any prospective resident.</p> <p>There is a clause in the admission agreement related to when a resident's placement can be terminated.</p>

<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>The sample of resident service delivery plans that were reviewed demonstrated that a nursing assessment is completed on admission, as is a nutritional assessment. An activities assessment is completed within three weeks of admission and a cultural assessment is completed between 10 days and three weeks. The primary assessment process, which is completed within three weeks of admission and reviewed six monthly is the interRAI assessment. All residents have up to date interRAI assessments completed by one of the trained interRAI registered nurse assessors on site.</p> <p>Information obtained from interRAI is further developed using validated nursing assessment tools as indicated. Examples of these include a pain scale; falls risk assessment, skin integrity assessment and nutritional screening. Once obtained, the information is collated to inform care planning.</p> <p>Care plans reviewed had an integrated range of resident-related information obtained from the pre-admission needs assessments, clinical reports, a GP review, formal assessment tools and interviews with key people such as the resident, family member(s) and others who may have been involved in their care and support prior to admission. Individualised goals had been developed as a result of these assessment processes.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>The sample of residents' care plans that were reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process. Other relevant clinical information is clear and detailed. In particular, the needs identified by the interRAI assessments are reflected in care plans reviewed. Service integration, including from external professionals and services was evident. Progress notes, activities notes, medical and allied health professional's records were clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.</p> <p>A folder containing all relevant service delivery records has been compiled for each resident and contains the care plan. The Bupa NZ</p>

		<p>care plan template is consistently used for all residents in both the rest home and the hospital services. Short term care plans are being implemented for short term problems. These are evaluated within appropriate timeframes and signed off when resolved; otherwise the issue is integrated into the long term care plan. Likewise, specific nursing plans for wound or diabetes management for example were in place as relevant. Examples of these processes were evident in the sample of residents' records reviewed.</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>Overall, the provision of care provided to residents in the Maxwell Care Home is consistent with their identified needs, their goals and their care plans. This was verified in the documentation sighted in service delivery plans, in observations made during the audit when staff demonstrated their commitment to the residents and also from the information obtained during resident, family, staff and manager interviews.</p> <p>Care staff are supported by the registered nurses to provide individualised high quality care. They informed they have easy access to the care plans and contribute to the progress reports. Each shift commences with a formal handover to ensure key updates are communicated and any changes for residents have been identified and passed on to ensure continuity of care. The GP was positive about the level of staff competence, is satisfied that medical input is sought in a timely manner and that medical orders are followed. Comment was made by the GP about the complexity of care in this facility and the high level at which staff operate to ensure residents' needs are met. A range of equipment and resources, suited to the levels of care provided is available.</p> <p>During interviews, residents stated that they could not have found a better facility, that the staff are excellent, and they have their needs met. Family members were generally positive about having their relative in the Maxwell Care Home, stated their relative seemed to be happy, was having their needs met and was safe.</p> <p>There were gaps in the service delivery for one person as specialist behavioural assessment, advice and support to improve the management of this resident had not been accessed. Also, their</p>

		significant weight loss had not been fully reviewed and addressed and a review process was overdue.
<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>	PA Low	<p>An activities programme is provided by an activities coordinator who is overseen by the manager. The manager is a trained diversional therapist who holds the national Certificate in Diversional Therapy. Each month the diversional therapist and the activities coordinator meet to discuss the activity programme for the following month as well as individual resident's needs and progress with their goals. The activities coordinator is responsible for residents' activity related documentation.</p> <p>A comprehensive social assessment and history and activity assessment is undertaken between three and six weeks following a resident's admission. This process is intended to ascertain the person's needs, interests, abilities and social requirements. The resident's activity needs are evaluated as part of the formal six monthly care plan review and involves a full reassessment process for each person.</p> <p>The planned monthly activities programme was sighted and the scheduled activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Examples include picnics, shopping, visiting entertainers, games, exercises, newspaper reading, quizzes and one on one activities that are personally focused.</p> <p>Residents interviewed stated there are plenty of options for everyone, that they select what they want to attend, enjoy the one on one time with the activities coordinator and confirmed they find the programme stimulating. Family members were positive about the options available but noted that there seemed to be a lot of downtime for residents.</p> <p>It was observed that there are considerable lengths of time when residents in this facility do not have formal planned activity input. The one on one activities are an important part of the activity programme for the residents in this facility; however, these time slots mean that other residents are not being stimulated at the same time. In addition, there are no planned activities from 4pm on a Thursday until 9am on a Monday. This has been raised for corrective action.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Low</p>	<p>The evaluation and review of resident care is reported in the progress notes on each shift. Any changes are reported to the registered nurse who is responsible for reviewing the situation and taking any relevant action(s).</p> <p>Formal multi-disciplinary care plan evaluations occur six weeks after admission and routinely every six months thereafter in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Residents and family members confirmed that they are invited to participate in the multi-disciplinary meetings and if unable to attend, the registered nurses provide them with feedback on the outcome. Stamps in residents' files confirmed the frequency of the GP visit with most documented for three month reviews. Examples of overdue medical reviews were found in residents' files.</p> <p>Evaluations are documented by the registered nurse against the relevant section of the care plan. Where progress is different from expected, the service responds by initiating changes to the plan of care and ensuring all staff are updated about them. Due to the clinical manager needing to orientate and upskill new registered nurses towards the end of 2017, a number of six week post admission reviews and routine six monthly reviews have become overdue. The interRAI reassessments for these people have been updated in preparation for the reviews and evidence of these was sighted. There were examples of updated evaluations and reviews in residents' files that did not clearly describe the level of achievement of personal goals and the reviews were more of an update or progress report. This was especially evident in the activity, culture and socialisation sections of the care plans.</p> <p>Examples of short term care plans, such as for skin tears, behaviour changes or infections, were consistently being reviewed. Progress on short term care plan goals is evaluated within timeframes as clinically indicated and depending on the degree of risk noted during the assessment process. Other plans, such as for wound management are evaluated each time the dressing is changed. Residents and families/whanau who were interviewed provided examples of their involvement in the evaluation of care planning goals and interventions</p>

		and any changes.
<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>Residents are supported to access, or seek referral, to other health and/or disability service providers when this is indicated. Although the service has a 'house doctor', residents may choose to use another GP so long as it is feasible to do so.</p> <p>If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. An example of this occurring was observed during the audit. Copies of referrals were sighted in residents' files, including to physiotherapy, occupational therapy, outpatients services, older persons' health and older person's mental health for example.</p> <p>Referrals are followed up by the registered nurse or the GP and correspondence from the specialist service consult is filed in the resident's personal file. The resident and family members are kept informed of the referral process, as verified by documentation sighted and interviews. Any acute/urgent referrals are attended to immediately, such as by sending the resident to accident and emergency in an ambulance depending on the circumstances.</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>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical</p>	FA	<p>A current building warrant of fitness (expiry date 1 July 2018) is publicly displayed.</p>

<p>environment and facilities that are fit for their purpose.</p>		<p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with personnel responsible for maintenance and observation of the environment. Efforts are made to ensure the environment is hazard free, that residents are safe and independence is promoted.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting.</p> <p>Residents confirmed they know the processes they should follow if any repairs or maintenance is required, any requests are appropriately actioned and that they are happy with the environment.</p> <p>New Provider Interview January 2018: HLL has undertaken a period of due diligence, including building reports, in preparation for purchase of each facility. There are presently no plans for any environmental changes in the facilities.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility, including three residents' rooms which have an ensuite. All other rooms share a bathroom between two rooms with lockable doors either side. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed. Door width and room size is adequate for the resident group; however corridor width provides a challenge to staff moving beds.</p> <p>There is room to store mobility aids, wheel chairs and mobility scooters. Staff and residents reported the adequacy of bedrooms.</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>	<p>FA</p>	<p>Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access their rooms for privacy, if required. Furniture is appropriate to the setting and residents' needs.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>Laundry is undertaken on site in a dedicated laundry, and by family members if requested. Care staff and dedicated laundry staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner.</p> <p>There is a small designated cleaning team who have received appropriate training. These staff are undertaking the New Zealand Qualifications Authority Certificate in Cleaning (Level 2), as confirmed in interview of cleaning staff and training records. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme and residents/family satisfaction surveys.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 26 October 2017. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's were</p>

		<p>sighted and meet the requirements for the number of residents. There is a water storage tower located in the garden. Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and staff are aware to call 111 for Police assistance if they have security concerns at night.</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 residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light and opening external windows that open onto outside garden or small patio areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	PA Low	<p>Every effort to minimise the risk of infection to residents, staff and visitors is being made through the implementation of an appropriate infection prevention and control programme. Infection control management is guided by an organisational level infection control manual, which is currently under review. The outcomes of the programme are being reviewed six monthly, in addition to six monthly internal audits on the different components of the infection control programme.</p> <p>A registered nurse is the designated infection prevention and control coordinator and was interviewed during the audit. Their role and responsibilities are defined in a job description, which was sighted. Infection control matters, including surveillance results, are reported monthly to the facility manager and tabled at the monthly infection control and quality/risk meetings. The infection control committee includes staff representation from the kitchen, health and safety, laundry and cleaning staff plus caregivers.</p> <p>At high risk times of the year, signage is available to place at the main</p>

		<p>entrance of the facility requesting anyone who is, or has been unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities and noted this was described during new staff orientation.</p> <p>The new service provider has a suite of infection control policies and procedures, which describe the responsibilities for all staff for infection control in the facility. Heritage Lifecare Limited has an infection control programme that was last reviewed in November 2015 and includes all aspects of the infection control system. It includes the responsibilities of the infection control coordinators and the functions of the quality committees in monitoring data.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The infection prevention and control coordinator is gaining appropriate skills, knowledge and qualifications for the role within the New Zealand setting. Meantime, the service provider has access to additional knowledge and expertise via the infection control team at the local hospital of the District Health Board, the local public health unit, laboratory staff and the GPs who attend residents at Maxwell Care Home. The infection prevention and control coordinator described their role and confirmed the availability of resources to support the programme and any outbreak of an infection.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in 2016 and include appropriate referencing. The new provider (Heritage Lifecare Limited) has their own set of infection prevention and control policies and procedures, which includes definitions of infections and an identification of infections form. There is a notifiable diseases list and a description of the surveillance of infections. Policies and procedures are reviewed two yearly, as with all documentation.</p> <p>Observations of staff following accepted practices for handwashing, use</p>

		of hand sanitisers and use of personal protective equipment confirmed their knowledge of basic infection control policy documentation. Staff interviewed verified knowledge of infection control policies and practices and confirmed they are required to read these during orientation.
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	PA Low	<p>Topics for staff education on infection control are noted in infection documentation and in quality meeting minutes. Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions.</p> <p>The registered nurse who has the role as infection control coordinator provided staff with their latest annual education session on a range of infection prevention and control topics. A record of attendance is maintained and was sighted. Additional staff education and reminders were provided to all staff by registered nurses during a suspected norovirus outbreak in 2017.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing and advice about remaining in their room if they are unwell.</p> <p>Staff receive annual training after orientation. However, the most recent staff education on infection prevention and control was provided by a person who does not have suitable qualifications to provide this level of training and this has been raised for corrective action.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Surveillance of infections is described in policy documentation. It focuses on the more frequently occurring infections within aged care facilities including urinary tract, gastro-intestinal, respiratory, eye, skin and ear, nose and throat, for example. Staff report any incidence on a suspected or confirmed infection on an incident/infection record. It is documented in a data collection log, reviewed by the infection control coordinator and details presented at the next monthly infection control meeting. Minutes of these meetings were sighted and demonstrated that analyses of infections is occurring and efforts to identify patterns are made. Corrective actions are raised as relevant with examples being the introduction of a new cleaning schedule for residents' rooms, the need</p>

		<p>for one chair to be cleaned each night, a request for new curtains and new mops. A suspected norovirus outbreak when a number of people experienced gastro intestinal symptoms was contained. Records of public health officials being involved for advice and review of actions were sighted as was evidence of staff education having been provided.</p> <p>Internal infection control audits are completed six monthly and results are reviewed. Results of the surveillance programme and the internal audits are shared with staff via regular staff meetings, at staff handovers and through monthly organisational quality meetings, which include infection updates. Graphs are produced that identify trends for six month periods. Data has been benchmarked externally with other Bupa aged care facilities.</p> <p>The new provider will implement similar systems whereby infection data is collated by the quality manager and reported through the senior management team to the general manager and board of Heritage Lifecare Limited (HLL). Benchmarking of data across the HLL facilities is to occur in the future.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities.</p> <p>On the day of audit, two residents were using restraints and two residents were using enablers, which were the least restrictive and used voluntarily at their request. A similar process is followed for the use of enablers as is used for restraints.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, files reviewed, and from interview with staff.</p> <p>New Provider Interview January 2018: HLL has policies and procedures in place to guide staff in the safe use of restraint and its minimisation as</p>

		well as for use of enablers. These policies are implemented across the group and a small number of restraint devices are approved for use following assessment. The prospective provider is experienced in the requirements of the standard, as it pertains to aged residential care.
<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 restraint approval group, made up of the Restraint Coordinator and the RN team, are responsible for the approval of the use of restraints and the restraint processes. It was evident from review of restraint approval group meeting minutes, residents' files and interviews with the coordinator that there are clear lines of accountability, that all restraints have been approved, and the overall use of restraints is being monitored and analysed.</p> <p>Evidence of family involvement in the decision making for restraints was on file in one case, and staff stated the family were involved although evidence of this was not found in the file of the second resident. Use of a restraint or an enabler is part of the plan of care in all four files.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>Assessments for the use of restraint were documented and included all requirements of the Standard. The RN undertakes the initial assessment with the restraint coordinator's involvement, and input from the resident's family/EPOA. The RN with the restraint coordinator role when interviewed described the documented process. One family interviewed confirmed their involvement. The general practitioner is involved in the final decision on the safety of the use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the resident's safety and security. Completed assessments were sighted in the records of residents who were using a restraint.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The use of restraint is actively minimised and the restraint coordinator described how alternatives to restraint are discussed with staff and family members (e.g., the use of sensor mats, and low beds).</p>

		<p>When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected.</p> <p>A restraint register is maintained, updated every month and reviewed at each restraint approval group meeting. The register was reviewed and contained all residents currently using a restraint and sufficient information to provide an auditable record.</p> <p>Staff have received training in the organisation's policy and procedures and in related topics, such as positively supporting people with behaviours that challenge. Staff spoken to understood that the use of restraint is to be minimised and how to maintain safety when in use.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>Review of residents' files showed that the individual use of restraints is reviewed and evaluated during care plan and interRAI reviews, six monthly restraint evaluations and at the restraint approval group meetings. The family interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process.</p> <p>The evaluation covers all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation completed as required.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>The restraint group undertakes a six-monthly review of all restraint use which includes all the requirements of this Standard. Six monthly restraint meetings and reports are completed and individual use of restraint use is reported to the quality and staff meetings. Minutes of meeting reviewed confirmed this includes analysis and evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use, the competency of staff and the appropriateness of restraint / enabler education and feedback from the doctor, staff and families. A six-monthly internal audit that is carried out also informs these meetings. Any changes to policies, guidelines, education and processes are implemented if indicated. Data reviewed, minutes and interviews with</p>

		the restraint coordinator, and RNs confirmed involvement in the restraint minimisation process.
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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 1.3.13.1</p> <p>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p>	PA Low	<p>There are a large number of residents who have been assessed as requiring modified food textures to ensure safe swallowing is maintained. In addition, many disliked the foods deemed as suitable for altered consistencies. During interview the cook described the difficulties in keeping to the menu, as approved by the dietitian, because not all items could be made into these consistencies. Efforts to keep to requirements whilst meeting residents' needs, were described. It became evident during discussion that this has meant there is no longer a surety that the specific nutritional needs of this group of residents are being met. There was</p>	<p>A menu has been reviewed and signed off by a dietitian; however, the cooks are finding that despite their efforts, the menus supplied are not consistent with the food preferences of the residents nor are the menu items always able to be modified in a way that meets the needs of the high number of residents in this facility who require a soft or puree diet.</p>	<p>A suitable menu that meets the needs and personal preferences of residents, whilst also meeting their nutritional needs, is approved by a registered dietitian.</p> <p>180 days</p>

		no evidence of widespread weight loss among residents.		
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Moderate</p>	<p>One resident, whose service delivery was reviewed in detail using tracer methodology, has been at the facility for approximately four months is receiving hospital level care and requires a wide range of complex cares. Family are closely involved. During a review of this person's service delivery records there was evidence of significant and progressive weight loss. 'Ensure' had been ordered; however, no further action had been taken other than to continue monthly weighs. This resident demonstrated considerable distress and their behaviour was impacting on other residents. Unsolicited feedback about the challenges this person was presenting was provided by residents and visitors. Prescribed medication had not made any difference. Staff informed they have tried everything and explained the actions they have taken to date. Evidence of the patience and skills with this person, by staff at all levels, was observed throughout the audit. The resident had not had the usual six week review; thus making the three monthly follow-up review also overdue.</p>	<p>One person with significantly disruptive behaviour has not been seen by a relevant health professional. Behaviour monitoring has not been documented, a behaviour management plan was not in place and significant weight loss had not been addressed.</p>	<p>This resident with adverse behavioural manifestations and significant weight loss requires a full review, including from relevant allied health professionals, to ensure the services provided are consistent with, and contribute to, meeting the person's assessed needs.</p> <p>30 days</p>

<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	<p>PA Low</p>	<p>Residents have activity assessments, goals and plans within their service delivery plans. An activities coordinator is responsible for implementing the activity programme for both rest home and hospital level care residents. A monthly activities programme of a mix of group and one on one activities is in place and is overseen by a trained diversional therapist (also the facility manager). The one on one activities are an important part of the activity programme for a significant number of residents in this facility; however, these time slots mean that other residents are not being stimulated at the same time. In addition, there are no planned activities from 4pm on a Thursday until 9am on a Monday, as the activities coordinator does not work during these timeframes. Relatives liked the options available but expressed concern about the infrequency of organised activities.</p>	<p>There are considerable lengths of time when residents in this facility do not have access to a social and recreational programme of activities that is meaningful to the resident(s), as required by the standard and the requirements of D16.5 c iii of the ARC agreement.</p>	<p>Planned social and recreational activities that are meaningful to the resident are provided at a frequency that more accurately community and cultural norms</p> <p>90 days</p>
<p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused, indicate the degree of achievement or response</p>	<p>PA Moderate</p>	<p>An evaluation and review process intended to check the level of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome for each resident,</p>	<p>Five resident care plans are overdue for their multi-disciplinary review. Two of these have been in the facility since October but have not had a six week follow-up review.</p>	<p>Evaluations and reviews are completed within the scheduled timeframes for each resident. The documentation will reflect the resident's degree of achievement, their response to</p>

<p>to the support and/or intervention, and progress towards meeting the desired outcome.</p>		<p>is in place. These are scheduled to occur six weeks following admission and six monthly reviews of care plans from then; however some in the sample and on the master list had not been completed within the required timeframe. Likewise, not all three monthly GP medical reviews had been completed within the timeframe. Reviews that had been completed did not always reflect the resident's level of achievement towards the personal goal and this was especially evident in the evaluations and reviews of activity, cultural and social goals.</p>	<p>GP/nurse practitioner reviews are not all occurring within the required timeframes and some files do not clarify the frequency of review required. Not all reviews sighted, in particular activities, report on progress with the personal goals; rather they are a progress report.</p>	<p>the intervention, and their progress towards meeting their personal goals.</p> <p>90 days</p>
<p>Criterion 3.1.3 The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.</p>	<p>PA Low</p>	<p>The organisation has a clearly defined IPC programme, developed at organisational level by the quality and risk team. The policies are evidenced to have been reviewed in the last two years and compliance with the programmes implementation at Maxwell Care Home is sighted. There is no documentation to verify the programme has been reviewed annually. This finding is verified by interviews with the IPC Coordinator, CM and documentation from the organisations quality management co-ordinator. The organisation has documented its commitment to reviewing the programme prior to</p>	<p>The infection control programme has not been reviewed within the last year.</p>	<p>To provide evidence the infection control programme is reviewed annually.</p> <p>180 days</p>

		the end of March 2018.		
<p>Criterion 3.4.1</p> <p>Infection control education is provided by a suitably qualified person who maintains their knowledge of current practice.</p>	PA Low	<p>The infection control coordinator is a registered nurse who has had minimal experience in this role and has not completed specialist training, other than undertaking an internal on-line training in infection control issues. This person provided the last annual infection control education session to other staff within the Maxwell Care Home in November 2017.</p>	<p>The most recent annual infection control staff education training was provided by a person who has not gained/maintained an appropriate level of knowledge of current infection control practice, as required by the standard.</p>	<p>Infection control education is provided by a suitably qualified person who has gained/maintained knowledge of current practice in the field.</p> <p>180 days</p>

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, there 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.