

Heritage Lifecare (BPA) Limited - Maxwell Care Home

Introduction

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

The audit has been conducted by 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); Rest home care (excluding dementia care)	
Dates of audit:	Start date: 15 January 2019	End date: 16 January 2019
Proposed changes to current services (if any):	None	
Total beds occupied across all premises included in the audit on the first day of the audit:	22	

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Maxwell Lifecare provides rest home and hospital level care for up to 25 residents. The service has been operated by Heritage Lifecare (BPA) Limited since February 2018 and is managed by a facility manager and a clinical services manager. Positive feedback about the care provided was reported by residents and family members.

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

This audit identified areas requiring improvement relating to the activity programme and the need for kitchen renovation.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

Services are provided that respect the choices, personal privacy, independence, individual needs and dignity of residents and staff were noted to be interacting with residents in a respectful manner.

Care for residents who identify as Maori is guided by a comprehensive Māori health plan and related policies.

There was no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

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

The service has linkages with a range of specialist health care providers, which contributes to ensuring services provided to residents are of an appropriate standard.

Residents and family members are aware of the complaints process. A complaints register is maintained with complaints resolved promptly and effectively.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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An overarching strategic plan and a facility specific business plan include the scope, direction, goals, values and mission statement of the organisation and Maxwell Lifecare. The governing body receives weekly and monthly reports on the functioning of the service and quality indicators. An experienced and suitably qualified person manages the facility.

Organisational policies and procedures that support service delivery are current and are reviewed regularly. The quality and risk management system includes the 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 as relevant. Actual and potential risks, including health and safety risks, are identified and mitigated.

Processes for the appointment, orientation and management of staff are based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery for residents. Regular individual staff performance reviews are undertaken. Rosters demonstrate that staffing levels, and the staff skill mix, are meeting the changing needs of residents.

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

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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The organisation works closely with the local Needs Assessment and Service Co-ordination Service, to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, sufficient and relevant information is provided to the potential resident/family to facilitate the admission.

Residents' needs are assessed by the multidisciplinary team on admission within the required timeframes. Shift handovers and communication sheets guide continuity of care.

Care plans are individualised, 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. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme is overseen by a newly appointed activities officer. 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, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Policies guide food service delivery, supported by staff with food safety qualifications. The kitchen was well organised. Residents verified overall satisfaction with meals.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The facility is older style and described by residents and family members as being 'homely'. Residents' rooms are personalised, and communal facilities are well used. Facility maintenance is attended to as required, there is a current building warrant of fitness

and fire safety systems are monitored by an external company. Electrical equipment and biomedical equipment are tested and/or calibrated as required. External areas are accessible, safe and provide seating.

Waste and hazardous substances are well managed. Protective equipment and clothing are available and being used by staff. Chemicals are stored safely. Cleaning and laundry processes, which are undertaken on site, are evaluated for effectiveness.

Emergency equipment and supplies are available. Staff are trained in emergency procedures, use of emergency equipment and supplies and practise fire evacuation drills regularly. The call bell response times are monitored and efforts to improve these have been made. Suitable security systems are in place.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation implements policies and procedures that support the minimisation of restraint. Three residents have voluntarily consented to use of an enabler to enhance their personal safety. There are no residents currently using a restraint. Comprehensive assessment, approval, monitoring and review processes are in place for the use of restraints and enablers. Staff described their knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

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

Standards applicable to this service fully attained.

The infection prevention and control programme, led by an experienced and appropriately trained infection control co-ordinator, aims to prevent and manage infections. Specialist infection prevention and control advice is accessed from the district health board. The programme is reviewed annually.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken, analysed, trended, benchmarked and results reported through all levels of the organisation. Follow-up action is taken as and when required.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	43	0	1	1	0	0
Criteria	0	91	0	1	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<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 (Maxwell) has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.</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>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation's standard consent form including for photographs, outings, invasive procedures and collection of health information.</p> <p>Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented where relevant in the resident's file. Staff demonstrated their understanding by being able to explain situations when this may occur.</p> <p>Staff were observed to gain consent for day to day care on an ongoing basis.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Brochures related to the Advocacy Service were readily available and accessible. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.</p> <p>Staff were aware of how to access the Advocacy Service.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' families and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</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/concerns/compliments policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families by the facility manager when a person is admitted to the service. Additional information and forms are available at the front desk alongside a complaints/suggestions box. Residents and family members interviewed were familiar with the complaints process. Staff described how the complaints/concerns and compliments process operates, knew what actions to take and confirmed they are updated on issues of concern. The facility manager described efforts being made to focus on concerns before they escalate and on compliments.</p> <p>The complaints register reviewed showed that 14 complaints have been received since the service came under the umbrella of HLL early in 2018. Actions taken, through to an agreed resolution, were documented and completed within the required timeframes. Any required follow up and improvements have been made where possible. An example of this was that staff were provided with additional training on manual handling, including the use of hoists, after five complaints about hoists not being used had been filed. The facility manager is responsible for complaints management and follow up. Analyses of complaints occurs at both the facility and organisational levels. There have been no complaints received from external sources since the previous audit.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Residents and family interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussion with staff. The Code is displayed in common areas. Brochures on the Code, together with information on advocacy services and other informative brochures are available beside the residents' notice board. Brochures on how to make a complaint and feedback forms is available in the entry foyer.</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>Residents and families confirmed that they receive services that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff understood the need to maintain privacy and were observed doing so throughout the audit, when attending to personal cares, ensuring resident information is held securely and privately, when exchanging verbal information and in discussion with families and the GP. All residents have a private room.</p> <p>Residents are encouraged to maintain their independence by being assisted to participate in community activities. Each plan included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed by staff and training.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>There were no residents in Maxwell Lifecare at the time of audit who identified as Māori, however interviews verified staff can support residents who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau to Māori residents. There is a current Māori health plan developed at organisational level with input from cultural advisers. A kaumatua from the local marae is available to offer advice and support to Maori residents if required.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's</p>	<p>FA</p>	<p>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences required interventions and special needs were included</p>

<p>Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>in all care plans reviewed, for example, food likes and dislikes and attention to preferences around activities of daily living.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. A general practitioner (GP) and the visiting nurse practitioner (NP) also expressed satisfaction with the standard of services provided to residents.</p> <p>The induction process for staff includes education related to professional boundaries and expected behaviours. All registered nurses (RNs) have records of completion of the required training on professional boundaries. Staff are provided with a Code of Conduct as part of their individual employment contract. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service encourages and promotes good practice through evidence-based policies produced at organisational level, input from external specialist services and allied health professionals, for example, the hospice/palliative care team, district nurses, physiotherapist, mental health services for older people, access to a wide range of in-service training opportunities and on-line learning portals. Staff at all levels are verified as competent in a range of skills. The GP and NP confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Other examples of good practice observed during the audit included an environment that was homely and relaxed. Call bells were answered promptly and were not heard to be continually ringing. Staff were observed to be promptly responsive to resident's needs, and respectful and helpful to each other. Residents stated they were happy and when given the opportunity had no areas of dissatisfaction, other than the lack of activities (refer criterion 1.3.7.1).</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and</p>	<p>FA</p>	<p>Residents and family members stated they were kept well informed about any changes to their own or their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. There was also evidence of resident/family input into the care planning process. Staff understood the principles of</p>

<p>provide an environment conducive to effective communication.</p>		<p>open disclosure, which is supported by policies and procedures that meet the requirements of the Code. A resident notice board is used to inform residents and families of any events and a regular newsletter has been initiated to keep residents and families informed. Residents meetings are held every three months. Residents have access to WiFi and several residents use email to communicate with family and friends. .</p> <p>Interpreter services can be accessed via Interpreting New Zealand when required. Staff reported interpreter services were rarely required due to all present residents being able to speak English.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>An overarching HLL strategic plan that was reviewed in 2018 is available. A site-specific business plan, as required for each HLL facility, was completed during the audit and presented to the auditor. These documents outline the purpose, values, scope, direction and goals of the organisation. They described annual and longer-term objectives and the associated operational plans. A sample of weekly and monthly reports, as provided to the support office of HLL, showed adequate information to monitor performance is reported including clinical quality indicators and key performance indicators related to issues such as occupancy, staffing, financial performance, and emerging risks and issues. The strategic and business plans sit alongside a comprehensive organisational quality and risk management plan.</p> <p>The service is managed by a suitably qualified and experienced facility manager who took on the role more than twelve months ago. This person has had extensive management experience across a range of fields and completed management and leadership training. Responsibilities and accountabilities are defined in a position description and individual employment agreement. The facility manager confirmed knowledge of the sector, regulatory and reporting requirements. Currency is maintained through participating in most on-site training, undertaking external professional development opportunities and maintaining regular links with local managers from similar types of services and organisations.</p> <p>The service provider holds contracts with the local District Health Board to provide rest home and hospital level care under the Aged Related Residential Care Agreement (ARRC) and respite care. It also delivers a Ministry of Health contract for Young Persons with Disabilities (YPD). On the first day of audit, there were four people receiving rest home level care and 18 receiving hospital level care, two of whom were under the YPD contract. No residents were receiving respite care and there were three empty beds.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the</p>	<p>FA</p>	<p>When the facility manager is absent, the clinical services manager carries out specific required duties under delegated authority. This person has completed leadership training. An operations manager from HLL is on call during any such absence and HLL quality team expertise is also available.</p> <p>During absences of key clinical staff, the clinical management is overseen by other senior registered</p>

<p>service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>		<p>nurses who are experienced in the sector and able to take responsibility for any clinical issues that may arise. There is also access to the clinical manager from another nearby facility who is advised of any pending absence of the clinical services manager. Staff reported the current arrangements work well.</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 responses to and management of incidents and complaints, audit activities, a regular patient satisfaction survey, monitoring of outcomes, clinical incidents including infections, any use of restraints or enablers and quality improvement processes.</p> <p>Both quality meeting minutes and staff meeting minutes reviewed confirmed regular review and analysis of quality indicators. Related information is reported and discussed at the various meetings held. Staff reported their involvement in quality and risk management activities through participation in internal audits, attending meetings or reading minutes, making efforts to reduce the number of incidents and taking on roles such as health and safety officer. Relevant corrective actions and quality improvements are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually; however, results of the first under HLL, which is also the most recent survey were not available as the surveys are currently being analysed. According to the schedule, results are due in February 2019. Examples of quality improvements implemented from internal audit results and from HLL reports on quality indicators included additional staff training on manual handling, changes in task lists, development of relationships with some external organisations and increased monitoring of some clinical tasks.</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. Heritage Lifecare Limited are currently in the process of progressively reviewing all documentation to ensure it meets the needs of the facilities and is applicable for the introduction of the electronic recording systems. 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. A generic organisational risk register is in place and the facility manager reviews these alongside the risks specifically identified for Maxwell Lifecare. Existing quality and risk monitoring systems cover most of the review requirements.</p> <p>The manager is familiar with the Health and Safety at Work Act (2015) and supervises the health and safety officer who is responsible for ensuring the requirements are implemented. A hazard register is in place and there was evidence of ongoing reviews of this register.</p>

<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incident forms reviewed showed these were fully completed by the facility manager (for staff incidents) or the clinical services manager (for residents' incidents), as appropriate. The registered nurse on duty is responsible for the open disclosure process with the resident and family members. Incidents are investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated and analysed at the local level and are a component of the quality indicators report that goes to the HLL support office every month, where the information is further analysed.</p> <p>The facility manager described essential notification reporting requirements, including for outbreaks, pressure injuries and near miss sentinel events. Clarification was provided as to the responsibilities for reporting such events by support office and/or the facility manager. They advised there have been no notifications of significant events made to the Ministry of Health since the provisional audit approximately a year ago.</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 practices and relevant legislation. The recruitment process includes referee checks, personal interviews, police vetting and validation of training, qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented, records are maintained and that good staff recruitment records from previous owners of the facility have also been retained. A file of APCs showed these are being checked annually and copies of relevant documentation are available for all registered nurses, GPs, pharmacists, the podiatrist and the dietitian who are associated with the service.</p> <p>Staff orientation includes all necessary components relevant to the role. During interview, staff expressed satisfaction with the current orientation processes for new staff. The manager has revised the process as part of a continuous quality improvement initiative to ensure it will better prepare staff to work with the residents at Maxwell Lifecare. Staff records reviewed show documentation of completed orientation checklists for all staff both before and since HLL purchased the facility. A performance review after a three-month period is now being undertaken and records of these were viewed for staff employed since HLL commenced.</p> <p>Continuing education is planned on an annual basis, according to a list of mandatory training requirements. A calendar of these requirements is updated when the training session(s) are organised, and the type of presentation is noted. Additional special interest topics are organised for staff education and individual staff may request to undertake a specific external training, if relevant to their role. Attendance records are maintained, and a topic may be repeated if staff attendance is low. Care staff</p>

		<p>have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. There are sufficient trained and competent registered nurses (four of seven with one booked for February 2019) who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated overall completion of the required training and completion of annual performance appraisals as they fall due.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>The organisational policies on 'Safe Staffing of HLL Aged Care Facilities' and on the roster and time sheets provide guidance for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). Staffing levels are being adjusted to meet the changing needs of residents, including changes in occupancy levels, with 'floaters' staff hours extended or an extra staff person rostered. An after-hours on call roster is in place with the facility and clinical services managers rotating for these duties, although the facility manager still needs to contact the clinical services manager for anything clinical. Additional clinical support is available through a sister facility nearby should this be required, such as when the clinical services manager is not able to be contacted. Staff confirmed that there is sufficient access to additional advice when needed. There is an emergency evacuation scheme register, which details the assistance required for each resident in the event of an emergency and how to contact next of kin, in the roster folder.</p> <p>Caregivers reported that for the current resident numbers there are adequate staff available to complete the work allocated to them. Residents and family interviewed supported this, although said how busy the staff are and how hard they work. Observations and review of eight weeks of the roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. Staff use a staff shift change form for any planned absence and unplanned absences are managed by the use of casual staff or people who typically work four days a week but are willing to pick up an additional shift.</p> <p>As all registered nurses have a current first aid certificate, there is always at least one staff member on duty who has a current first aid certificate as there is 24 hour/seven days a week registered nurse coverage in the facility. Registered nurses administer medicines on all shifts and any second checker, or second sign required is undertaken by a senior caregiver, all of whom are required to have this competency. A senior caregiver is allocated to a 'long shift' on the morning and afternoon shifts and this person leads the caregiver team. The clinical services manager is employed in this role full time Monday to Friday.</p>
<p>Standard 1.2.9: Consumer Information Management</p>	FA	<p>The resident's name, date of birth and National Health Index (NHI) number are used on labels as the unique identifier on all residents' information sighted. All necessary demographic, personal, clinical and</p>

<p>Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>		<p>health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p> <p>Electronic medication records are stored in a secure portal.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and meet with the facility manager (FM) or the clinical services manager (CSM). They are also provided with written information about the service and the admission process.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the Nelson Marlborough District Health Board's (NMDHB) 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family. At the time of transition between services, appropriate information, including medication records and the care plan is provided for the ongoing management of the resident. All referrals are documented in the progress notes.</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>	FA	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These</p>

		<p>medications are checked by an RN against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review is consistently recorded on the electronic medicine chart.</p> <p>There were no residents who were self-administering medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner if required.</p> <p>Medication errors are reported to the RN and CSM and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.</p> <p>Standing orders are not used.</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>FA</p>	<p>The food service is provided on site by a cook and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been developed at an organisational level by a qualified dietitian.</p> <p>A food control plan is in place and was registered with the Marlborough District Council 11 June 2018. All aspects of food procurement, production, preparation, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook and kitchen staff have undertaken safe food handling qualifications.</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 accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and residents' meeting minutes. Any areas of dissatisfaction were promptly responded to. Pureed diets are uniquely prepared at Maxwell Lifecare to ensure they are visually appealing to the resident.</p>

		<p>Pureed food is moulded into shapes that are indicative of the non-pureed food. Interviews verify improved satisfaction with meals and increased appetite of residents since the introduction of this initiative.</p> <p>Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There are sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed.</p> <p>Several maintenance issues in the kitchen were identified as requiring improvement, refer to criterion 1.4.2.4</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>If a referral is received, but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. There is a clause in the access 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>	FA	<p>On admission, residents of Maxwell Lifecare are initially assessed using a range nursing assessment tools, such as a pain scale, falls risk, skin integrity, nutritional screening, social and recreational assessment and depression scale, to identify any deficits and to inform initial care planning. Within three weeks of admission residents are assessed using the interRAI assessment tool, to inform long term care planning. Reassessment using the interRAI assessment tool, in conjunction with additional assessment data, occurs every six months or more frequently as residents changing conditions require.</p> <p>In all files reviewed, initial assessments are completed as per the policy and within 24 hours of admission. InterRAI assessments are completed within three weeks of admission and at least six monthly unless the resident's condition changes. Interviews, documentation and observation verify the RNs are familiar with requirement for reassessment of a resident using the interRAI assessment tool when a resident has increasing or changing need levels.</p> <p>All residents have current interRAI assessments completed by four trained interRAI assessors on site. InterRAI assessments are used to inform the care plan.</p>
<p>Standard 1.3.5: Planning</p>	FA	<p>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment</p>

<p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>		<p>process and other relevant clinical information. The needs identified by the interRAI assessments are reflected in the care plans reviewed.</p> <p>Care plans evidenced service integration with progress notes, activities notes, medical and allied health professional's notations clearly written, informative and relevant. Any change in care required was 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 resident with a recent weight loss, has documentation in place that complies with the organisation's planning processes around the management of weight loss. A computer-generated concern is initiated when a 5% weight loss is recorded. The resident's GP is informed and the resident is managed as per the GP's instructions. The resident concerned has been seen and examined by the GP. Possible causes to be investigated and a meal supplement ordered. The resident's weight is to be monitored weekly and the resident to be reviewed by the GP in a month. A review of weight loss data for the past year at Maxwell Lifecare evidences only one case where a resident has lost more than 5% of their body weight.</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>FA</p>	<p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP and NP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>PA Low</p>	<p>The activities programme presently operating at Maxwell Lifecare is provided by a recently appointed activities officer.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. A planned monthly activities programme was sighted. The activities programme sighted reflected residents' ordinary patterns of life. Individual, group activities and regular events are offered. Examples include visiting entertainers, quiz sessions, housie, bowls and daily news updates. The programme is evidenced to have lengthy periods where it has not been operating and residents have not had access to a social and recreational programme.</p>
<p>Standard 1.3.8: Evaluation</p>	<p>FA</p>	<p>Apart from the activities programme referred to in criterion 1.3.7.1, residents' care is evaluated on each</p>

<p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>		<p>shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans were consistently reviewed for infections, pain and weight loss, and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans were evaluated each time the dressing was changed. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a main medical provider, residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP, NP or CSM sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to older persons' mental health services. Referrals are followed up on a regular basis by the CSM, NP or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</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>	<p>FA</p>	<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 their representatives also provide relevant training for staff. Material safety data sheets were available where chemicals are stored. Staff interviewed knew what to do should any chemical spill/event occur. Three spill kits are available. There are three skip bins available. Food waste, garden waste, general waste and hazardous substances, which is primarily double bagged continence products, are disposed of in these and a contractor removes three times a week, and as needed.</p> <p>There is provision and availability of protective clothing and equipment including plastic aprons, gloves, goggles and a face shield. Hand sanitiser is readily available in dispensers throughout the building. Staff were observed using protective equipment and hand sanitiser appropriately.</p>
<p>Standard 1.4.2: Facility</p>	<p>PA</p>	<p>A current building warrant of fitness with an expiry date of 1 July 2019 is publicly displayed. Fire equipment and building safety checks are being completed according to the fire safety company</p>

<p>Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>Moderate</p>	<p>schedule.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. Any broken equipment or identified hazard is reported to a designated maintenance person who addresses the issue in a timely manner. The testing and tagging of electrical equipment and calibration of bio medical equipment was current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. Checks of mechanical equipment including wheelchairs and hoists, for example, are undertaken according to the schedule as detailed in policy documents. External companies are contracted to support the checking of equipment. The environment was hazard free, residents were safe and independence promoted. The kitchen area requires renovation and has been raised for corrective action.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting. Tidy garden and lawn areas with stamped concrete and paved paths and patio areas are provided.</p> <p>Residents confirmed they are happy with the environment and family members confirmed any required repairs or maintenance is actioned appropriately.</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. This includes ten shared ensuites of toilets and shower areas, four independent ensuites and three other shared toilets. An additional hand basin is in each resident's room. One person is taken to an ensuite across the hallway for toileting and shower purposes. Appropriately secured and approved handrails are provided in the toilet and 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>The residents' rooms range in size and although staff commented that some of the smaller ones, especially their ensuites, are difficult to use a hoist in, they noted that if a resident's needs increase that the resident is usually transferred to a larger room. There is otherwise adequate personal space 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.</p> <p>There is room throughout the facility to store mobility aids, wheel chairs and mobility scooters. Residents and family members reported satisfaction with the 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>	FA	<p>There is a main lounge and dining area, a smaller lounge which is often used for an overflow of residents who require extra assistance with their meals and a third smaller lounge. Residents can also use a seating area that has two chairs and a bookcase. Most activities are undertaken in the main lounge/dining area. The dining and lounge areas are not overly spacious; however, family, staff and residents described them as homely. Residents can access areas 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>	FA	<p>Laundry is undertaken on site in a dedicated laundry by Maxwell Lifecare staff employed for the role. Caregivers on night shift and at weekends assist as needed. On the day of audit, the laundry staff person demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents and family members 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 have completed chemical handling training, as confirmed in interview of cleaning staff and training records sighted. Chemicals were stored in a key pad lockable cupboard and were in appropriately labelled containers. Laundry chemicals are attached to the machines and metred doses automatically dispensed by the machine.</p> <p>Cleaning and laundry schedules were available, and the associated processes are monitored through the service provider's internal audit programme. The most recent of these was in September 2018 with good results for both cleaning and laundry services.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>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 on the 19 January 2011. A trial evacuation takes place six-monthly with a copy sent to the required agency with the most recent being November 2018, although the manager informed another will be undertaken later in January to bring the trial evacuations into line with the new owner's schedule. 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 sighted and meet the requirements for full occupancy of residents.</p>

		<p>Contents are checked regularly according to the schedule. Drinking water is stored in bottles according to local civil defence recommendations and changed every four months. There is a generator on site that is checked by the maintenance person.</p> <p>Call bells for everyday use and for emergency responses alert staff to residents (or staff) requiring assistance. Call system audits are completed on a regular basis. Following the most recent of these a quality improvement process was implemented to improve response times. Residents and families reported staff respond promptly to call bells, although noted they can sometimes get very busy.</p> <p>Appropriate security arrangements are in place. Windows have security latches in place and doors and windows are locked at a predetermined time with access only via staff responding to the front door call bell. In addition to security checks coinciding with staff checks of residents, security checks are signed off by the afternoon staff before leaving and the night staff following commencement of their shift.</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>Rooms have natural light and opening external windows. There are doors along corridors that open onto outside garden or small patio areas.</p> <p>All residents' rooms and communal areas are heated and ventilated appropriately. Ceiling heaters are in residents' rooms and communal areas such as hallways. A heat pump for heating and cooling has been installed in the main lounge and dining area and another in the kitchen. Free standing fans are used to assist with cooling during summer months. Quotes for a central ducted heat pump to be installed in two wings and the reception area were sighted. Monthly records of indoor temperatures in random areas around the facility demonstrated comfortable indoor air temperatures are maintained. Residents and families confirmed the facility is 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>	FA	<p>Maxwell Lifecare provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, developed at organisational level. The infection control programme and manual are reviewed annually.</p> <p>The RN with input from the CSM is the designated infection control coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the FM and tabled at the quality/risk/staff meetings. Infection control statistics are entered in the organisation's electronic database and benchmarked within the organisation's other facilities. The organisation's national quality manager is informed of any IPC concern.</p> <p>Signage at the main entrance to the facility requests 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</p>

		they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities.
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The infection control coordinator (ICC) has appropriate skills, knowledge and qualifications for the role, having undertaken post graduate training in infection prevention and control, as verified in training records sighted. Well-established local networks with the infection control team at the DHB are available and expert advice from the organisation's clinical support team is available if additional support/information is required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The ICC and CSM 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 IPC policies reflect the requirements of the IPC standard and current accepted good practice. Policies were reviewed at organisational level within the last year and included appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves, as was appropriate to the setting. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation and documentation verified staff have received education in IPC at orientation and ongoing education sessions. The ICC provides education. Content of the training was documented and evaluated to ensure it was relevant, current and understood. A record of attendance was maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. An example of this occurred when there was a norovirus outbreak in January 2018.</p>

		Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell and increasing fluids during hot weather.
<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 is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and skin infections. When an infection is identified, a record of this is documented in the resident's clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>The ICC and CSM review all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via quality and staff meetings and at staff handovers. Surveillance data is entered in the organisation's electronic infection database. Graphs are produced that identify trends for the current year, and comparisons against previous years. Data is benchmarked internally within the group's other aged care providers.</p> <p>Graphs indicated the incidence of infections at Maxwell Lifecare is low.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Recently reviewed (October 2018) restraint minimisation and safe practice 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 documents described different staff roles and responsibilities, include definitions for terms such as enabler and restraint, state that accepted options are lap belts/Tbelts, bed rails and fall out chairs, and described processes for approval, implementation, monitoring of restraints and enablers. Restraint and enabler approval are undertaken by the national restraint approval group.</p> <p>Interviews with the clinical services manager, the facility manager, the restraint coordinator and staff confirmed that a full review of the policy documentation and additional staff education on the topic has clarified some differences in opinion on the use of restraints and enablers. A restraint in-service training session was delivered in October 2018. Restraint competencies had subsequently been completed for most staff and signed off accordingly.</p> <p>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, practice, role and responsibilities. On the day of audit, there were no residents using a restraint and the restraint coordinator reported that restraint is only used as a last resort when all alternatives have been explored.</p>

		<p>The restraint register noted that the last record of use of restraint was in November 2018 when a full review of restraint use was undertaken and it was decreed that the identified restraints were actually enablers. Related documentation was changed. Three residents were voluntarily using bedrails at their request and according to their file had all consented to using the bedrails as an enabler. Residents are checked according to the one to two hourly checks completed during the night shift and progress notes include comments on their use.</p>
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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)
Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	PA Low	<p>A previous corrective action around the limited availability of an activities programme for residents' last audit was signed off by the South Island Alliance Programme Office (SIAPO) in July 2018. There has been limited availability of activities since July 2018, as verified by documentation, resident, family, staff and FM interviews.</p> <p>There was no evidence of the activities assessments of individual residents having been reviewed regularly to ensure they meet their needs. Likewise, there had been no regular reviews or evaluations to help formulate an activities programme that is meaningful to the resident group. A residents' meeting was last held in July 2018. The minutes of this meeting makes no mention of input from residents regarding their satisfaction with the programme.</p>	The previous recreation programme operating at Maxwell Lifecare has had lengthy periods where it was not operating. The present planned activities programme has only been operating since 7th January 2019, and evidence is unavailable to verify it maintains strengths, skills and the interests that are meaningful to the residents, and is being delivered consistently.	Provide evidence activities are planned, developed and facilitated and meet the ongoing needs of the residents.

		<p>Minutes of meetings between the FM and the previous recreation officer, in May, July and November 2018 identify activities are not occurring as per the documented activities programme. In October 2018, an initiative was implemented by the FM to address the limited activities programme. The corrective actions required are ongoing and the plans for change continue to be implemented.</p> <p>An activities officer was employed at the beginning of January 2019 and had been in the role for a week prior to audit. The activities officer's previous experience has been as a caregiver; however the person has support to enhance skills for the role from another activities officer and a local diversional therapy support group.</p> <p>An activities programme is sighted that evidences a range of activities to be offered in line with resident's interests and includes quizzes, games, church services, entertainment, feeding the birds, short story and newspaper reading, happy hour and pet therapy.</p> <p>A facility van is shared with another facility and is available for outings; however, there have been no group outings in the past six months. Processes are in place to enable the newly appointed activities officer to attain the required skills (i.e. driver's license, First aid certificate) to take residents out in the van. The activities officer has started a range of initiatives to meet the residents' needs, including a residents' newsletter to keep everyone informed. Residents and family commented on the recent improvement around activities now being offered over the past week.</p>		180 days
<p>Criterion 1.4.2.4</p> <p>The physical environment minimises risk of harm, promotes safe mobility, aids</p>	<p>PA</p> <p>Moderate</p>	<p>The on-site kitchen is in a bad state of disrepair. Maintenance is completed as possible. Staff have made considerable efforts to maintain the cleanliness of the area, but overall deterioration of the surfaces is creating challenges to maintain its cleanliness at a safe level.</p> <p>Paint on wooden surfaces is worn, peeling and chipped, the</p>	<p>Deteriorating painted wooden surfaces, collapsing insect screens on windows, lifting vinyl and ingrained dirt in rough surfaces in the kitchen are presenting potential infection risks in food preparation areas and health and</p>	<p>Renovation of the kitchen is undertaken to ensure potential</p>

<p>independence and is appropriate to the needs of the consumer/group.</p>		<p>wood is scuffed and dented, sliding cupboard doors are off their railings, fly screens are falling apart and accumulated and ingrained kitchen dirt is in corners and around windows to an extent that deep cleaning is unlikely to resolve. The vinyl on the kitchen floor is splitting at joins, it has peeled back in some areas and accumulated kitchen dirt is evident in corners.</p> <p>Meals are prepared on site and to date there has been no indication of residents contracting food-borne illness resulting from the dilapidated state of the kitchen. Nor have there been any significant staff accident or illness reported associated with the state of the kitchen. However, the compromised integrity of kitchen walls, storage areas and floors are presenting potential risks to the health and safety of residents and staff.</p>	<p>safety risks to workers.</p>	<p>risks to food safety and the health and safety of staff are minimised.</p> <p>90 days</p>
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Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, 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.