

# Heritage Lifecare Limited - Maygrove Lifecare

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## Introduction

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

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

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

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

The specifics of this audit included:

**Legal entity:** Heritage Lifecare Limited

**Premises audited:** Maygrove Lifecare

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 21 November 2019      End date: 21 November 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:** 40

# Executive summary of the audit

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## Introduction

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

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

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

## Key to the indicators

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

<b>Indicator</b>	<b>Description</b>	<b>Definition</b>
	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

Maygrove Lifecare is owned and operated by Heritage Lifecare Limited (HLL). The home provides rest home level care for up to 43 occupants. The care home manager was on leave at the time of audit. The registered nurse was present on the day of audit.

This unannounced surveillance audit was conducted against the Health and Disability Services Standards and the provider's contract with the district health board. The audit process included the review of policies and procedures, the review of residents' and staff files, observations and interviews with residents, family members, managers, staff, the regional quality manager, the regional operations manager and the general practitioner.

The registered nurse reported there have been no changes to size or scope of the service since the previous audit.

There were no areas identified as requiring improvement at the last audit. At this audit seven areas have been identified as requiring improvement. These relate to complaints management, having policies / procedures and the hazard register available for staff, monitoring aspects of the quality programme, corrective action planning, staff orientation and ongoing training/competencies, and timeliness of interRAI assessments.

## 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.

Some standards applicable to this service partially attained and of low risk.

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

The complaints management process is documented.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.

Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

The business plans and other documents detail the scope, direction, goals, values and mission statement of the organisation. An experienced and suitably qualified person manages the care home, supported by an experienced registered nurse.

The quality and risk management system includes collection of quality improvement data, internal audits, conducting annual resident, relative and staff satisfaction surveys, restraint minimisation, and monitoring residents' infections. Adverse events are

being reported. Policies and procedures are developed and updated nationally by Heritage Lifecare Limited and distributed to Maygrove Lifecare.

The appointment of staff is based on current good practice. Staff are provided with an orientation and ongoing education.

Staffing is provided to meet residents' identified needs.

## 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 multidisciplinary team, including the registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised based on a comprehensive range of information and accommodate any new problems that might arise. Residents' records are reviewed regularly.

The planned activities calendar provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents and families interviewed verified satisfaction with the meals.

## **Safe and appropriate environment**

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.

Standards applicable to this service fully attained.

The facility has a current building warrant of fitness. There have been no changes required to the fire evacuation plan. Regular fire drills are conducted.

## **Restraint minimisation and safe practice**

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.

Standards applicable to this service fully attained.

The organisation has implemented policies and procedures that support the minimisation of restraint. There were no residents using enablers or restraints at the time of audit. The use of restraints and enablers is monitored monthly.

## **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.

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

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	12	0	3	1	0	0
Criteria	0	31	0	6	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

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld.	PA Low	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and was available at the main entrance. Residents and family members interviewed knew about the complaints process.</p> <p>The care home manager (CHM) is responsible for complaints management and follow up. Staff interviewed confirmed an understanding of the complaints process and what actions are required. The complaints register does not include details of all complaints. Actions taken in response to some complaints is not sufficiently documented. There have been no complaints received from the Health and Disability Commissioners (HDC) office or the District Health Board (DHB) since the last audit.</p>
Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an	FA	Staff interviewed understood the principles of open disclosure which are supported by policies and procedures that meet the requirement of the Code. Residents and family members are asked during admission about when communication is to be made by staff with family members following accidents or incidents. Family members interviewed stated they were kept well informed about any changes to their relative's health status and were advised in a timely manner about any incidents or accidents. These communications were documented in the residents' clinical notes and incident records sampled. The family are also contacted about the outcomes of regular and / or any urgent medical reviews.

environment conducive to effective communication.		All residents can communicate effectively in English. Interpreter services are available if required. The registered nurse (RN) knew how to access interpreter services, although has not required this service for some time.
Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	<p>The business plan 2019-2020, outlines the purpose, values, scope, and goals of the organisation.</p> <p>The service is managed by the care home manager who was appointed to this role commencing 9 September 2019. The care home manager is a registered nurse with a current annual practising certificate (APC). The care home manager was on leave on the day of audit. The new care home manager is appropriately experienced and has exceeded the professional development requirements to meet the provider's contract with Waitemata District Health Board (WDHB). The care home manager is supported by the Heritage Lifecare Ltd (HLL) regional operations manager and the regional quality manager, who were both interviewed during audit. The regional operations manager interview was via phone. The regional quality manager arrived on site during the audit and confirmed knowledge of the sector, regulatory and reporting requirements. A sample of the care home manager's monthly reports to the regional operations manager showed information to monitor performance is reported including occupancy, staffing, incidents, risk, and operational issues. The operations manager was satisfied appropriate issues are being communicated in a timely manner.</p> <p>The care home manager is assisted by an experienced registered nurse. The registered nurse was the Maygrove Lifecare interim care home manager for designated periods in 2019 while recruitment for a permanent care home manager was occurring. The registered nurse has worked at Maygrove Lifecare for many years.</p> <p>There were 40 residents present during the audit. The service holds a contract with Waitemata District Health Board (WDHB) for the provision of Age-Related Residential Care (ARRC) at rest home level of care. There are 39 residents receiving services under this contract. One resident under the age of 65 years is receiving services funded by the Ministry of Health. Emails sighted from Taikura Trust confirmed an agreement for the provision of services is currently being developed. One other contract is held with WDHB for Long Term Support, Chronic Health Conditions (LTS CHC) at rest home level of care. There were no residents receiving services under this contract at the time of audit.</p>
Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and	PA Moderate	<p>Maygrove Lifecare has a quality and risk management system which is understood and implemented by service providers. The quality and risk programme includes resident, relative and staff satisfaction surveys, incident and accident reporting, reporting maintenance issues / needs, monitoring the use of restraint, infection surveillance and complaints / compliments. These topics were included in the monthly staff meeting minutes sighted.</p> <p>Reported incidents are included in clinical and non-clinical indicators and reported on monthly. It is unclear if all reported events are being included due to filing / administration issues.</p> <p>The results of the resident and relative satisfaction survey are reviewed and analysed by the national support office.</p>

<p>maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>The results of the 2019 survey have not been analysed and communicated as yet.</p> <p>Policies and procedures are reviewed nationally by HLL and distributed to the care homes. The care home manager is responsible for document control processes. New or significant changes to document content are discussed with staff at various meetings. Staff are unable to access policies and procedures for reference after hours, and the process for staff to review and sign updated policies is inconsistently occurring. The current Maygrove Lifecare hazard register could not be located.</p> <p>The care home manager's monthly report to the regional operation manager includes an area to identify changes in risk. Three of the Maygrove Lifecare care home manager's monthly reports were sighted. The regional operations manager confirmed having regular communications with the care home manager and this included discussion on new risks. Staff advised they would report new hazards to the care home manager or RN or note maintenance issues that require addressing. Remedial action had been taken for these sampled reported events.</p> <p>Internal audits have not been conducted since 1 August 2019. Corrective action planning is not consistently documented and/or reviewed.</p> <p>Resident and family members interviewed were happy with the services provided by the registered nurse, the activities coordinator, care and auxiliary staff.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Policy and procedure details the required process for reporting incidents and accidents and near miss events. Staff advise they are provided with education on their responsibilities for reporting and managing accidents and incidents during orientation and as a component of the ongoing education programme, for example falls prevention. Records were not available to demonstrate staff have consistently completed orientation and ongoing education / competency requirements (refer to 1.2.7.4 and 1.2.7.5).</p> <p>Applicable events are being reported and actions taken in response to sampled incidents. Staff report accidents / incidents via a paper-based reporting system and discuss new events during their shift handover. Completed incident reports are filed in individual resident's file as observed during audit, and the incident notification form was completed. A review of incidents, including several falls and a resident absconding, demonstrated investigations were conducted and appropriate actions taken in response to each event. Family members verified they had been informed of relevant events in a timely manner.</p> <p>A range of events are monitored monthly as clinical and non-clinical indicators by HLL. The care home manager enters reported events onto an electronic record that is used to inform quality indicator reports. A number of paper-based incident reports were located amongst other documents in various areas of the care home manager's office. It is unclear if these events have been included in the indicator data. This is included in the area for improvement raised in criterion 1.2.3.7. The RN is currently responsible for review and oversight to ensure appropriate actions have been taken. The indicators included falls with and without injuries, skin tears, pressure injuries, weight loss, behaviours, restraint/enabler use, compliments/complaints and infections. Reported events are discussed at staff</p>

		<p>meetings.</p> <p>The regional quality manager advised that essential notifications have been made since the last audit and copies of these were sighted. The events included the appointment of an interim care home manager, the new care home manager appointment, essential utility outages, fire brigade attending, a resident absent without staff knowledge, and gastroenteritis event. No coroners' investigations have occurred since the last audit. The regional quality manager could detail the type of events that are required to be reported.</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>	PA Low	<p>Recruitment processes include completing an application form, conducting interviews and reference checks. Police vetting is occurring and is facilitated by staff in the Heritage Lifecare Ltd (HLL) national support office. An employment contract and a confidentiality declaration were in staff members' files reviewed. Staff are to read and sign the HLL code of conduct.</p> <p>Records were sighted that demonstrate all registered health professionals (both employed and contracted) have a current annual practising certificate.</p> <p>Staff are provided with an orientation relevant to their role. Records of completion are not consistently maintained. While ongoing education has been provided, this has not been as frequent as planned/required and current records detailing staff completion of HLL competency assessment programme were not able to be located. These are areas requiring improvement.</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>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). There is always a minimum of two caregivers on duty, with more on morning and afternoon shifts. 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 members 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. The care home manager is an experienced aged care RN with a current annual practising certificate (APC). There is one other RN employed who works full time. The RN is on call when not on site. The RN has recently completed the interRAI competency requirements and has been working to undertake interRAI assessments in addition to the RN's other clinical responsibilities. Some interRAI assessments are overdue (refer to 1.3.3.3). Laundry, catering, cleaning, administration and maintenance services are provided by employed staff that work regular rostered hours.</p> <p>At least one staff member on duty has a current first aid certificate.</p> <p>The regional operations manager advised Maygrove Lifecare is recruiting for a casual RN. A letter of offer has been made to an applicant. The activities coordinator position has been advertised in the last week to replace the current</p>

		activities coordinator. There is a full-time caregiver vacancy (night shift). This is currently being covered by other staff employed.
Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	<p>The medication management policy was current and identified 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 the audit. The staff member observed demonstrated good knowledge and had a clear understanding of their role and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform this role.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Any excess stock and medications following discharge of a resident are returned to the pharmacy as soon as possible as per the process in place.</p> <p>Any controlled drugs are pre-packaged by the pharmacist if needed for a resident. Weekly checks are performed with two staff and at the time of administration two staff check the medication required. There were no controlled drugs in use at the time of audit.</p> <p>The records of temperatures for the medicine fridge were reviewed and were within the required temperature.</p> <p>An electronic medicines management system is in use. Monitoring occurs weekly to ensure all documentation of medication administration and prescribing is up to date and meeting audit and best practice standards. This is a newly implemented Heritage Lifecare Limited (HLL) initiative. In addition six monthly audits are performed as part of the internal audit schedule.</p> <p>All requirements for pro re nata (PRN) medicines were met. The required three-monthly medication reviews were consistently recorded electronically. There are no standing orders.</p> <p>There were no residents self-administrating medications at the time of the audit. Appropriate processes were in place to ensure this is managed in a safe manner, when required.</p> <p>There was an implemented process for reporting, responding to and analysing any medication errors.</p>
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management	FA	The food service is provided on site by a chef/cook and kitchen team and was in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years (dated March 2018). Any recommendations made at the time have been implemented.

<p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration which expires 03 October 2020. Food temperatures, including for high risk items are monitored appropriately and recorded as part of the plan. The chef interviewed and kitchen team (there are three cooks and five kitchen hands) have undertaken safe food handling qualifications and certificates are framed and displayed in the kitchen.</p> <p>A nutritional assessment is undertaken by the RN for each individual resident on admission to the facility and a dietary profile developed. The personal preferences, any special diets and modified textures if needed are made known to the chef and/or kitchen staff and accommodated in the daily meal plan. Special equipment to meet resident's nutritional needs is available. The daily menu is displayed in the dining room which is located close to the kitchen providing a homely atmosphere. Both residents and family interviewed stated they enjoyed all the meals and baking provided on a daily basis.</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>	FA	<p>The documentation reviewed did not verify that the care provided to residents was always consistent with their documented needs, goals and the plan of care (refer to 1.3.3.3). The attention to meeting a diverse range of resident's individualised needs was evident with staff/family interviews and observations in all areas of service delivery. The GP interviewed verified that medical input is sought in a timely manner, that medical orders are followed, and care is managed well by the RN and care staff. Care staff confirmed that teamwork is provided at all times. A range of resources and equipment was available suited to rest home level care 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>	FA	<p>The activities calendar of activities reviewed is provided by an activities coordinator. The calendar is displayed in all service areas of the facility. The activities coordinator interviewed has worked in the role for nearly three years.</p> <p>An assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities calendar that is meaningful to the residents. The resident's activity needs are evaluated six monthly and as part of the six-monthly care plan review.</p> <p>The activities sighted in progress reflected residents' goals, ordinary patterns of life and included normal community activities. A van is available for outings in the community. Individual, group activities and regular events are offered.</p> <p>Residents and families are involved in evaluating and improving the planned activities through residents' meetings held regularly and satisfaction surveys annually. Residents interviewed enjoyed the calendar of events and the outings in the community and any special theme days organised. 'Happy hour' occurs fortnightly and this is enjoyed by the residents. Family members interviewed stated that they can join in the activities anytime. The activities</p>

		coordinator completes a monthly activities report for the care home manager who reports to head office.
Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is evaluated on each shift and reported in the progress records. If any changes are noted it is reported to the RN. Formal care plan evaluations occur every six months in conjunction with the six monthly interRAI re-assessment. The RN does not have the interRAI re-assessments currently up to date and the respective care plans as noted in criterion 1.3.3.3). On a day to day basis changes to the care plans are made if the resident's health status changes. Examples of short-term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted, for example, wounds, skin tears, eye infections and upper and lower respiratory infections. Residents and families interviewed provided examples of involvement in evaluation of progress and any resulting changes.
Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A current building warrant of fitness (expiry date 10 June 2020) was publicly displayed. There have been no changes to the facility that have required a change in the approved fire evacuation plan. Staff attend fire evacuation/fire safety training. There is ongoing refurbishment / renovation of bedrooms as they become available. The corridor and lounge areas have been repainted and have new carpet.
Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, wound, fungal, soft tissue, eye, gastro-intestinal, the upper and lower respiratory tract and skin conditions. The RN is the infection prevention and control coordinator (ICC). The ICC reviews all reported infections, and these are documented. Any new infections and any required management plans are discussed at the shift hand-over to ensure early intervention occurs.  Monthly surveillance data is collated and analysed at the support office to identify any trends, possible causative factors and required actions. Results of surveillance are shared with staff via regular staff/quality meetings and at staff handovers. Graphs are produced that identify trends for the current year and comparisons against the previous year and this is reported to the care home manager. An outbreak of gastro-enteritis involving 15 residents and five staff occurred since the previous audit. The records reviewed over the period from 30 January 2019 to 11 February 2019 showed that all appropriate reporting and management of the outbreak was recorded. When an infection outbreak or an increase in infection incidence has occurred, there was evidence that additional staff education has been provided in response and this was evident in the training records reviewed.

Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised.	FA	The organisation has policies and procedures related to safe restraint practices. There were no enablers or restraints in use at the time of audit. Policy identifies that the use of enablers is voluntary for the safety of residents in response to individual requests. The use of enablers and restraints was monitored monthly. Staff demonstrated knowledge and understanding of the restraint and enabler processes. Staff have been provided with training on restraint minimisation and use of enablers.

## Specific results for criterion where corrective actions are required

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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 1.1.13.3 An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.	PA Low	A complaints register was sighted. The complaints register does not include details of all complaints received. A complaint received on 13 July 2019 is included in the complaints folder but has not been recorded on the complaints register. One resident's file reviewed (selected at random) included information in the last three months related to a written 'concern' received from an external service, and the response to another complaint. Neither had been noted in the Maygrove Lifecare complaints register. The response to the 'concern' was not available to be reviewed. The complaint received was not present in documents sighted, only the response letter was sighted. It was unclear if the complaints response addressed all the issues raised by the complainant. This complaint is ongoing as the complainant is not satisfied with the initial response provided. A complaint received earlier in 2019 was acknowledged and responded to within two days. The email to the complainant was present, however the response letter that was noted to be an attachment to the email was not present in the complaints register and associated documentation sighted. Other complaints sighted had been acknowledged, investigated and responded to within	The complaints register does not include details of all complaints received. Complaints related documentation (either the complaint or response) was not available for review for some sampled complaints.	Ensure the complaints register includes details of all complaints and that appropriate records are consistently available related to each complaint.  90 days

		timeframes that comply with the Code and appropriate records of the communications related to these complaints retained.		
Criterion 1.2.3.4  There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.	PA Low	<p>Folders containing policies and procedures are present on site. The documents are developed nationally by HLL and distributed to care homes. The policy / procedure manuals on site are now kept in the care home manager's office and are not available to staff for reference if required when the care home manager or registered nurse are not on site.</p> <p>The updated policies and procedures are discussed at staff meetings as verified with staff interviewed. Staff are required to read and sign that they have read the updated documents. The folder of new and updated policies is kept in the nurses' station. Only one staff member has signed as having read one set of the assorted policy updates issued from July 2019 onwards in variance to the organisation's requirements.</p> <p>The current Maygrove Lifecare hazard register was unable to be located.</p>	<p>The policy and procedure manuals are in the care home manager's office and are not accessible to staff when the care home manager or registered nurse are not on site. The hazard register could not be located.</p> <p>Since July 2019, only one staff member has read and signed as having read one set of updated policies / procedures in variance to the organisation's requirements.</p>	<p>Ensure policies and procedures and the hazard register are available for staff to access when required.</p> <p>Staff consistently read updated policies/procedures and sign that this has occurred.</p> <p>180 days</p>
Criterion 1.2.3.7  A process to measure achievement against the quality and risk management plan is implemented.	PA Low	<p>There is an internal audit schedule which covers relevant aspects of service including (but not limited to), aspects of care, clinical practice, the facility, documentation and medicine management. The internal audits scheduled since 1 August 2019 had not been completed. The registered nurse advised the focus has been on providing care to residents. Where audits have been completed prior to this date, corrective actions plans are not consistently documented and / or monitored for effectiveness (refer to 1.2.3.8) for sampled audit events.</p> <p>Staff, resident and relative satisfaction surveys have been conducted prior to July 2019. The results of these have not been evaluated /</p>	<p>Internal audits have not been undertaken since 1 August 2019.</p> <p>The resident, relative and staff satisfaction surveys were conducted earlier in 2019. The results have not been evaluated as yet or communicated to Maygrove Lifecare.</p>	<p>Undertake internal audits as scheduled.</p> <p>Evaluate and report the results of the resident, relative and staff satisfaction surveys conducted in early 2019.</p> <p>Ensure all</p>

		<p>reported as yet. The results have not been included in the HLL survey report issued in September 2019 as an older version of survey documents were used for some responses, and some relatives provided feedback on the resident survey form, so information received was not directly comparable with the other HLL facilities.</p> <p>Incidents are reported by staff. Sampled events have been investigated and followed up (refer to standard 1.2.4.5). Several incident reports were sighted in various locations around the care home manager's office area, at times mixed in with other documents. The incidents forms sighted included events reported in 2017, late 2018 and the last three months. It was unclear if all reported events are being included in the quality indicator programme.</p>	<p>Incidents are being reported and included as part of the Heritage Lifecare indicator reporting programme. However, there is not a consistent process of filing these documents to ensure all reported events are included.</p>	<p>completed incidents reports are filed in a logical manager to ensure the accuracy of the quality indicator data.</p> <p>90 days</p>
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	<p>PA Moderate</p>	<p>If an issue or deficit is found, a corrective action was put in place to address some situations. This included following individual incidents / accidents sampled, infections, and in response to new maintenance / facility issues reported. However, corrective action plans have not been consistently developed following internal audits, or if developed, did not include all applicable issues. For example, the temperature of hot water in three residents' areas was noted to be above 45 degrees Celsius (recorded as being 46 or 47 degrees Celsius) each month when tested as detailed in the last three-monthly audit reports sighted. The audit notes each month that 'tempering valves are set at 45 degrees' and 'will monitor'. Action plans have not been developed in response to the staff record, education and competencies audit and residents' rights audit. A process to monitor that the actions have been undertaken and monitored for effectiveness is not consistently occurring.</p> <p>The actions taken in response to all sampled complaints is not able to be verified as some complaints documentation neither the complaints letter or response was not available for review (refer to criterion 1.1.13.3).</p>	<p>Corrective actions plans are not consistently developed when areas for improvement have been identified. This includes in response to internal audits or complaints. When action plans are developed, there is limited evidence that all required actions have been implemented and monitored for effectiveness.</p>	<p>Consistently develop corrective actions plans when areas for improvement are identified.</p> <p>Implement a process to monitor that corrective actions have been undertaken and assess their effectiveness.</p> <p>90 days</p>

Criterion 1.2.7.4  New service providers receive an orientation/induction programme that covers the essential components of the service provided.	PA Low	Staff advised they are required to complete a health and safety induction and an orientation programme relevant to their role. A checklist is utilised to ensure all relevant topics and the required competencies are included. New employees are buddied with senior staff for orientation shifts. The duration of orientation depends upon the new staff member's previous experience and their role; however, staff note the orientation includes at least three shifts. The care home manager reports on the number of orientation hours provided each month in the care home manager's monthly report. Records were not available to demonstrate that the three staff whose records were reviewed, employed in July and August 2019 have completed the HLL orientation requirements. The sample size of staff files reviewed was expanded.	While staff interviewed advise they are provided with an orientation relevant to their role, records verifying completion were not sighted in three out of three staff files sampled for staff employed in July 2019 and August 2019.	Maintain records to demonstrate that new staff complete orientation requirements in a timely manner.  90 days
Criterion 1.2.7.5  A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	A staff education programme is in place that details the topics to be included and the frequency. The topics are included to align with Maygrove Lifecare's contract with WDHB, residents' care needs, and in response to quality and risk data. In-service education has been provided monthly.  Education provided in 2019 included moving and handling, first aid, restraint minimisation, falls prevention, nutrition and hydration, food handling, complaints, communication, and continence. Records of education are maintained. Not all topics scheduled have been completed as the RN has been the interim care home manager for periods during 2019 and has also been working to complete interRAI assessments. Education that has not been provided within HLL suggested timeframes includes but is not limited to, sexuality / intimacy, privacy and confidentiality, emergency management including civil defence, behaviours that challenge, informed consent, enduring power of attorney and advance directives.  A competency programme for health care assistants and registered nurses is in place and commences during orientation. This included medicine competency for applicable staff, hand hygiene, moving and handling/use of the hoist, restraint minimisation and infection	There is a staff ongoing education and competency assessment programme. Records verifying applicable staff have completed the required competencies were not available for review during audit.  Staff training is not consistently occurring as planned. Topics that have not been included in the timeframes required by HLL included sexuality / intimacy, privacy and confidentiality, emergency	Provide education in accordance with Maygrove Lifecare (Heritage Lifecare Limited) staff education programme.  Maintain records to demonstrate staff have completed the competency requirements as required by Heritage Lifecare Limited.  90 days

		<p>prevention and control. A spreadsheet was sighted detailing some of the training and competencies staff have completed. The regional quality manager advised the spreadsheet sighted during audit was not the most recent version recently sighted. The current version was not able to be located during audit.</p> <p>A discussion is held with new staff three months after employment. Following this annual performance appraisals are to be undertaken. A register is maintained detailing when appraisals are due. Annual appraisals were completed in applicable sampled files or were now due.</p> <p>All residents and family members interviewed spoke positively about the care provided by the RN and the care, activities and auxiliary staff.</p>	<p>management including civil defence, behaviours that challenge, informed consent, enduring power of attorney and advance directives.</p>	
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA Low</p>	<p>The interRAI documentation was reviewed. The RN has endeavoured to ensure that the interRAI re-assessments are being reviewed in a timely manner and that the care plans are updated. However, this was not able to be verified when the 'resident listing assessments due' document was printed off Momentum during audit and reviewed. The interventions are therefore not consistently being changed to meet and/or reflect the assessed needs, interventions and desired outcomes of the individual residents.</p>	<p>The RN responsible for the interRAI assessments was interviewed. The current resident interRAI assessments and care plan reviews are not being completed within the required timeframes. Five resident interRAI assessments were overdue. Four of the five were two months overdue and one interRAI was one month overdue. The care plans reviewed were not consistently updated with the required interventions to meet the assessed</p>	<p>Ensure the interRAI re-assessments are completed within the required timeframes and that the care plans are updated appropriately to ensure they are current, up-to-date and available to guide care staff.</p> <p>180 days</p>

			needs/goals set for all individual residents.	
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## **Specific results for criterion where a continuous improvement has been recorded**

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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 audit.

No data to display

End of the report.