# Mayfair Lifecare (2008) Limited - Mayfair Lifecare

## 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 BSI Group New Zealand Ltd, 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:

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| **Legal entity:** | Mayfair Lifecare (2008) Limited |
| **Premises audited:** | Mayfair Lifecare |
| **Services audited:** | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) |
| **Dates of audit:** | Start date: 27 September 2021 End date: 28 September 2021 |

**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:** 66

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

## General overview of the audit

Mayfair Lifecare is part of the Arvida aged care residential group. The service provides hospital (medical and geriatric) and rest home level care for up to 86 residents, including rest home level care in 23 serviced apartments. On the day of audit, there were 66 residents in total. The residents, relatives and general practitioner commented positively on the care and services provided at Mayfair Retirement Village.

This unannounced surveillance audit was conducted against the relevant Health and Disability Services Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of resident and staff files, observations, and interviews with relatives, management, staff, and the general practitioner.

The village manager (non-clinical) is temporarily overseeing the operations at Mayfair Lifecare since May 2021 whilst a new village manager is appointed. This role is supported by a clinical manager who has experience in aged care.

This audit identified an improvement required around progress notes entries.

## Consumer rights

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| 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. |

The rights of the resident and/or their family to make a complaint is understood, respected, and upheld by the service. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns have been managed and a complaints register is maintained.

## Organisational management

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| 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. |

The organisation's philosophy, aims, values and quality objectives are documented.

The quality management systems included incident/accident reporting, risk management, resident and staff satisfaction surveys, restraint minimisation, and infection control data collection. Appropriate policies and procedures are available for staff reference.

Quality activities are conducted, and this generates improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes. An annual resident/relative satisfaction survey is completed and there are regular resident/relative newsletters. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and followed through. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. An education and training programme has been implemented with a current training

plan in place. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. Registered nursing cover is provided 24 hours a day, 7 days a week.

## Continuum of service delivery

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| 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. |

The registered nurses are responsible for each stage of service provision. The registered nurses assess, plan and review residents' needs, outcomes, and goals with the resident and/or family/whānau input. Care plans viewed in electronic resident records demonstrated service integration and were evaluated at least six-monthly. Resident files included medical notes by the general practitioner and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Qualified nurses and senior caregivers responsible for administration of medicines complete annual education and medication competencies. The medicine charts reviewed met prescribing requirements and were reviewed at least three-monthly by the general practitioner.

The activity team provide and implement an interesting and varied integrated activity programme. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical, cultural, and cognitive abilities and resident preferences.

Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on site. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

## Safe and appropriate environment

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| 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. |

Mayfair Lifecare had a current building warrant of fitness. There had been no changes made to the building since the last audit. There is an approved fire evacuation plan and an annual maintenance plan that includes testing of equipment. The internal and external environment is safe and appropriate for the residents.

## Restraint minimisation and safe practice

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| 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 restraint minimisation and safe use policy and associated procedures includes definitions that comply with the standard. Staff are provided with training on restraints and enablers during orientation and the ongoing staff training/competency assessment programme. There were no residents with a restraint or enabler in use at the time of audit.

## Infection prevention and control

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| 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 trained infection control coordinator, aims to prevent, and manage infections. Specialist infection prevention and control advice is accessed when needed. Covid-19 screening declarations and signing in at reception are in place to monitor visitors and contractors.

## 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) |
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| **Standards** | 0 | 15 | 0 | 1 | 0 | 0 | 0 |
| **Criteria** | 0 | 40 | 0 | 1 | 0 | 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) |
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| **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 |
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| Standard 1.1.13: Complaints Management<br><br>The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints procedure is provided to residents and relatives on entry to the service. Complaints forms are in a visible location at the entrance to the facility and in each unit. The village manager maintains a record of all complaints, both verbal and written. There have been five complaints logged since the previous audit. Two complaints made in 2019 (since the last audit) and three complaints received in 2020. No complaints have been received in 2021 year to date. The complaints reviewed were well documented with evidence of appropriate follow-up actions taken. Documentation including follow-up conversations and resolution, demonstrates that complaints are being managed in accordance with guidelines set by the Health and Disability Commissioner (HDC). A complaint made through HDC in March 2020 is currently being investigated and is still open. An HDC letter received in August 2021 requested more information as part of the investigation process. The service proactively commenced corrective actions in April 2020. Corrective actions relate to clinical documentation and education. Discussions with residents and relatives confirmed they were provided with information on complaints and complaints forms. Interviews with thirteen staff (two registered nurses, one chef, eight caregivers and two wellness leaders) confirmed their understanding of the complaint processes in relation to their roles.<br><br>The village manager has regular meetings with the residents to discuss any concerns that they may have. |
| Standard 1.1.9: | FA | Accident/incidents, complaints procedures and the policy and process around open disclosure alert staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. |

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| Communication<br><br>Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | | Ten incidents/accidents forms selected for review indicated that family/whānau were informed where required. Four residents interviewed (two hospital including a younger person with disabilities and two rest home level of care) stated they were welcomed on entry and were given time and explanation about the services and procedures. The young person with disabilities (YPD) stated she can choose her routine and the ways she maintains her community links. Two relatives (two hospital) interviewed stated that they are kept informed when their family member's health status changes. A monthly newsletter is produced for residents and relatives keeping them informed on facility matters and activities. An interpreter policy and contact details of interpreters is available. The residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement. A site-specific introduction document provides information for family, friends, and visitors to the facility. Family members interviewed stated they receive information related to Covid-19 prevention strategies including limited visiting hours. |
| Standard 1.2.1: Governance<br><br>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Mayfair Lifecare is owned and operated by the Arvida group. The service provides care for 86 residents, 63 care beds and 23 serviced apartments. On the day of audit, there were 66 residents in total, 34 rest home level care, including 8 in the serviced apartments, and 32 hospital level care residents, including five in the dual-purpose rooms in the Randolph (rest home) wing. All residents except one resident (YPD hospital resident in Cressy wing) are on the aged related residential care contract (ARRC). There are no double rooms.<br><br>The serviced apartments are used for rest home residents only. There are the eight dual-purpose rooms situated in the Randolph wing (28 rooms) and are close to the hospital wing (and near both nurses' stations).<br><br>There is an interim transition village manager (non-clinical) who also manages another Arvida facility and has been in the role (interim role) since May 2021 and in a management role within Arvida for seven years. She divided her time between the two facilities but confirmed that she spent the majority of her time (five mornings Monday to Fridays) at the current facility. The previous village manager was in the role for five years. At the time of the audit the new village manager was already appointed to the role with a scheduled start date. She is supported by an experienced clinical manager who has been in the position since August 2019, having previously worked in aged care and the DHB. The village manager and clinical manager are supported by the national leader of wellness and care and the national quality leader.<br><br>The village manager provides a monthly report to the Arvida CEO on a variety of operational issues. Arvida has an overall business/strategic plan. The organisation has a philosophy of care, which includes a mission statement. Mayfair lifecare has a business plan 2020/2021 and a quality and risk management programme.<br><br>The village manager and clinical manager have completed in excess of eight hours of professional development in the past twelve months. |

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| Standard 1.2.3: Quality And Risk Management Systems<br><br>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | There is an implemented quality and risk management system in place at Mayfair Lifecare which is designed to monitor contractual and standards compliance. There is a 2020/2021 business/strategic plan that includes quality goals and risk management plans. There is an established culture of seeking to continually review and analyse data to improve resident outcomes. The village manager and clinical manager are responsible for providing oversight of the quality and risk management system on site, which is also monitored at organisational level. Interviews with staff confirmed that there is discussion about quality data at various facility meetings. Arvida Group policies are reviewed at least every two years.<br><br>Data is collected in relation to a variety of quality activities and an internal audit schedule has been completed. Areas of non-compliance identified through quality activities are actioned for improvement. All staff interviewed could describe the quality programme corrective action process. Restraint and enabler use (when used) is reported within the bi-monthly quality improvement and three-monthly clinical/RN meetings. Residents/relatives are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff, and families. The February 2021 resident/relative satisfaction survey overall result shows customer satisfaction and customer loyalty rate (a net promoter score of 35). Improvements were identified around the food service and a corrective action plan; this is ongoing. Resident/family meetings occur two-monthly, and the results of the satisfaction survey have been discussed at the meeting.<br><br>The service has a health and safety management system that is regularly reviewed. Risk management, hazard control and emergency policies and procedures are being implemented and are monitored by the health and safety committee at the monthly meeting. There are also monthly national health and safety meetings conducted online through 'Team' meetings. The village manager and clinical manager are part of the health and safety committee. Hazard identification forms and an up-to-date hazard register is in place. The service had weekly meetings during Covid-19 throughout the alert levels. Falls prevention strategies are implemented including identifying residents at higher risk of falling and the identification of interventions on a case-by-case basis to minimise future falls. |
| Standard 1.2.4: Adverse Event Reporting<br><br>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and | FA | There is an accidents and incidents reporting policy. The clinical manager investigates accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at staff meetings including actions to minimise recurrence. An RN conducts clinical follow-up of residents. Ten incident forms reviewed for August 2021 demonstrated that appropriate clinical follow-up and investigation occurred following incidents. Neurological observation forms were documented and completed for three reviewed unwitnessed falls or potential head injuries. Discussions with the village manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There has been one section 31 notification made since the previous audit for a stage 3 pressure injury. A section 31 notification was made on the last day of the audit to notify the Ministry of Health of the change of manager. One notification made to the public health service for a gastro outbreak in July 2019 (sighted). |

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| where appropriate their family/whānau of choice in an open manner. | | |
| Standard 1.2.7: Human Resource Management<br><br>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | There are human resource management policies in place. The recruitment and staff selection process requires that relevant checks be completed to validate the individual's qualifications, experience, and veracity. Five staff files were reviewed (one clinical manager, one RN, two caregivers and one food services manager). There is evidence that reference checks were completed before employment was offered. Annual staff appraisals were evident in all staff files reviewed. A copy of practising certificates and competencies is kept. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Completed orientation, post-orientation interviews are on files and staff described the orientation programme.<br><br>The in-service education programme for 2020 has been completed and the plan for 2021 is being implemented. Discussions with the caregivers and RNs confirmed that Altura online training is available and implemented by staff. More than eight hours of staff development or in-service education has been provided annually. There are seven RNs at Mayfair Lifecare and five have completed interRAI training. The village manager, clinical manager and RNs are able to attend external training, including sessions provided by the DHB.<br><br>Following the HDC complaint all registered nurses completed training related to pain management, documentation and observation and wound and pressure injury management in April to June 2021. All registered nurses and two Wellness Leaders have a current first aid certificate.<br><br>There are 44 caregivers in total with 27 having achieved a National Certificate. Eighteen have achieved level 4, and nine have achieved level 3. Competencies completed by staff included medication, insulin, wound care, manual handling, hand hygiene, syringe driver and restraint, there was an up-to-date register. |
| Standard 1.2.8: Service Provider Availability<br><br>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | Arvida Mayfair Lifecare policy includes staff rationale and skill mix. Sufficient staff are rostered on to manage the care requirements of the residents. The service has a total of 73 staff in various roles. Staffing rosters were sighted and there is staff on duty to match needs of different shifts. The new appointed village manager will work 40 hours per week from Monday to Friday and are available on call after hours. In addition to the village manager, the clinical manager works five days a week (Monday to Friday), there is at least one RN on at any one time. The RN on each shift is aware that extra staff can be called on for increased resident requirements. Interviews with staff, residents and family members confirmed there are sufficient staff to meet the needs of residents. The caregivers interviewed stated that they have sufficient staffing levels.<br><br>Registered nurses have 'paperwork' days once a week to catch up with interRAI assessments and care planning.<br><br>Across the two hospital wings Cressy and Seymour (27 hospital residents including one YPD and five rest home |

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| | | residents), there is one RN on duty in the morning and one RN afternoon and the night shift. They are supported by six caregivers; (one senior caregiver and three caregivers 7.30 am to 4.30 pm, one caregiver 7.00 am to 1.00 pm, and one caregiver 7.00 am to 1.30 pm) on the morning shift. The afternoon shift has five caregivers (two from 4.30pm to 11.30pm and two from 4pm to 10pm and one from 4.30pm to 9pm). Night shift has two caregivers' midnight to 7am.<br><br>In the Randolph rest home wing (21 rest home residents and five hospital residents), there is one RN on duty on the morning shift. Senior caregivers (medicine competent) covering Monday to Sundays on PM and night shift with the support from the hospital RN. They are supported by three caregivers; (7am to 3pm, and one caregiver 7.30am to 3.30pm and one 7.30am-1.30pm) on the morning shift. Two caregivers in the afternoon shift (one 3.30 pm to 11.30 pm and one caregiver 4pm to 9pm).<br><br>The serviced apartments (eight rest home residents) have a separate roster with one senior caregiver (medication competent) on duty on the morning 7am to 3.45 pm) Monday to Sunday, supported by one caregiver 7am to 1.30pm. The afternoons have one senior caregiver 3.30 pm to 11.30 pm, and one 4.30 pm to 9 pm, one medication competent caregiver is on nightshift. The apartments are a wing off the main rest home/hospital. The nurses' station is in close proximity to the serviced apartment wing and registered nurses oversee the residents in the apartments. All senior caregivers are medicine competent.<br><br>Wellness leaders (activities) are allocated to the rest home and hospital.<br><br>There are designated food services staff, cleaning, and laundry staff seven days a week. |
| Standard 1.3.12: Medicine Management<br><br>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | There are policies and procedures in place for safe medicine management. Medications are stored safely in the medication room (hospital). Clinical staff who administer medications (RNs and senior caregivers) have been assessed for competency on an annual basis and attend annual medication education. Registered nurses have completed syringe driver training with the hospice. All medication (blister packs) are checked on delivery against the electronic medication system medication charts by two RNs. The bulk supply order for hospital level residents have expiry dates and stock levels checked monthly. There were no residents self-medicating on the day of the audit. The medication fridge and room temperature are checked as per policy, and temperatures are maintained within the acceptable temperature range. All eye drops sighted in the medication trolleys were dated on opening. Standing orders are not used.<br><br>Ten medication charts were reviewed and met prescribing requirements. Medication charts had photo identification and allergy status notified. The GP had reviewed the medication charts three monthly. 'As required' medications had prescribed indications for use. |

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| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management<br><br>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The food services are overseen by a chef/kitchen manager. All meals and baking are prepared and cooked on site by qualified chefs who are supported by cook assistants, morning, and afternoon kitchenhands. All food services staff have completed food safety training. The Arvida seasonal menu is reviewed twice yearly and includes resident preferences. The main meal is the lunch meal. Buffet breakfasts are in place in line with the Arvida Living Well model. The cook receives resident dietary profiles and notified of any dietary changes for residents. Dislikes and special dietary requirements are accommodated including food allergies and gluten free diets. The menu provides pureed/soft meals. The kitchen is adjacent to the main dining room and meals are plated in the kitchen and served to residents in the rest home and hospital dining rooms. Meals are delivered in the bain-marie to the serviced apartments kitchenette for serving.<br><br>The food control plan is current and expires 14 June 2022. Freezer, fridge and end-cooked, reheating (as required), cooling and serving temperatures are taken and recorded daily. The dishwasher rinse and wash temperatures are taken and recorded. All perishable foods and dry goods were date labelled. A cleaning schedule is maintained. Staff were observed to be wearing appropriate personal protective clothing. Chemicals were stored safely.<br><br>Residents provide feedback on the meals through resident meetings and resident survey. The kitchen manager receives feedback directly, both verbally and through resident meetings. Residents and relatives interviewed spoke positively about the choices and meals provided. |
| Standard 1.3.6: Service Delivery/Interventions<br><br>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Residents interviewed reported their needs were being met. The family members interviewed stated their relative's needs were being appropriately met. When a resident's condition alters, the registered nurse initiates a review and if required a GP visit or nurse specialist consultant. Care plans reflect the required health monitoring interventions for individual residents. Caregivers and RNs sign a care activity worklog with scheduled tasks and monitoring charts including repositioning, bowel chart, behaviour chart, food and fluid chart, weight, blood pressure monitoring, blood sugar levels, neurological observations, and toileting regime. Monitoring charts are utilised. Family are notified of any changes to health.<br><br>Wound assessments, wound management plans with body maps, photos and wound measurements were reviewed on eCase for ten residents with wounds (skin tears, chronic lesion, and venous ulcers). There were two pressure injuries on the day of audit (one stage two and one stage three). When wounds require a change of dressing, this is scheduled on the RN daily schedule. There is access to the wound nurse specialists at Nurse Maude and the plastics department at the DHB.<br><br>Care staff interviewed stated there are adequate clinical supplies and equipment provided including continence, wound care supplies and pressure injury prevention resources. There is access to a continence specialist as required. |

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| Standard 1.3.7: Planned Activities<br><br>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | There are three wellness leaders, one is a qualified diversional therapist who works full-time and has been in the role for more than five years. She is supported by two full-time wellness leaders that also covers weekends.<br><br>The programme is integrated (rest home including serviced apartments and hospital residents) from Monday to Friday. During the different Covid-19 risk levels each unit have a separate programme. Residents receive a copy of the programme which has set daily activities and additional activities, entertainers, outings, movies, sports on TV and resident led activities. There are two main areas for activities which are identified on the programme as the main lounge and the gallery which has been set up where activities can be set up any time. Resources are readily available in the gallery. There are volunteers, and caregivers are involved in weekend activities. One-on-one activities include individual walks, chats, and hand massage occurs for residents who are unable to participate in activities or choose not to be involved in group activities.<br><br>The activity team provide individual and group activities that align with the Wellness model of thinking well, engaging well, and moving well. These include (but are not limited to); daily exercise groups, newspaper reading, board games, quizzes, happy hours, outdoor garden walks and activities, book club, hand and nail care and bowls. Art classes have been introduced and observed on the day of audit. Community visitors include volunteers, SPCA pet therapy visits, church services, school children's groups, speakers, and entertainers. There are inter-home visits for bowls. Resident led groups include the ladies' group and men's group with their choice of activities and outings. The service has a van and hires a wheelchair taxi for outings into the community.<br><br>A resident leisure profile is completed soon after admission. Individual leisure plans were seen in resident electronic files. The wellness leaders are involved in the six-monthly review with the RN. The service receives feedback and suggestions for the programme through resident integrated meetings (rest home and hospital) and surveys. The residents and relatives interviewed were happy with the variety of activities provided.<br><br>The wellness leaders interviewed explained how they assist the younger person with disabilities to maintain their community links through supporting with transport and assisting with making appointments. |
| Standard 1.3.8: Evaluation<br><br>Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | All initial care plans for long-term residents were evaluated by the RN within three weeks of admission. Long-term care plans have been evaluated by the RN six monthly or earlier for any health changes in the electronic resident files reviewed. Family are invited to attend the multidisciplinary review meeting and case conference notes are kept on the electronic system. Written evaluations reviewed, identified if the resident goals had been met or unmet. The GP reviews the residents at least three monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the electronic progress notes. |
| Standard 1.4.2: | FA | The building holds a current warrant of fitness which expires 22 August 2022. The maintenance manager works full-time and is on the health and safety committee. There is a maintenance request book for repair and maintenance |

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| Facility Specifications<br><br>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | | requests located at the reception. This is checked daily and signed off when repairs have been completed. The planned maintenance schedule includes electrical testing and tagging, resident equipment checks, calibrations of weigh scales and clinical equipment and testing and tagging of electrical equipment. Monthly hot water tests are completed for resident areas and are below 45 degrees Celsius. Essential contractors/tradespeople are available 24 hours as required. A contracted gardener maintains the gardens and grounds. The service continues to develop households within the environment.<br><br>The corridors are wide and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas, courtyard and gardens were well maintained. All outdoor areas have seating and shade. There is safe access to all communal areas. There is a designated resident smoking area.<br><br>Caregivers interviewed stated they have adequate equipment to safely deliver care for rest home and hospital level of care residents. |
| Standard 3.5: Surveillance<br><br>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Infection surveillance is an integral part of the infection control programme and is described in the Arvida group infection control manual. Monthly infection data is collected for all infections based on signs, symptoms, and definition of infection. Infections are entered into the infection register on the electronic data base. Surveillance of all infections (including organisms) is entered onto a monthly infection summary. This data is monitored and analysed for trends monthly and annually. Infection control surveillance is discussed at facility meetings and meeting minutes are displayed for staff. Action plans are required for any infection rates of concern. Internal infection control audits are completed with corrective actions for areas of improvement. The service receives benchmarking feedback from support office. There has been one gastro outbreak recorded and reported to Public Health in July 2019. This was of short duration, contained and managed appropriately.<br><br>Hand sanitisers are appropriately placed throughout the facility. Visitors are asked not to visit if they are unwell. The majority of residents have received both doses of the Pfizer Covid-19 vaccine with staff vaccination ongoing in conjunction with the local DHB. Residents and staff are offered the influenza vaccine. Covid-19 scanning/manual sign in is mandatory on entry to the facility and the use of face masks are required as part of level 2 restrictions. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP and Arvida national quality manager who advises and provides feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility.<br><br>There is sufficient number of PPE stock available. |
| Standard 2.1.1: Restraint | FA | There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134. The policy includes comprehensive restraint procedures and identifies that restraint be used as a last resort. The service |

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| minimisation<br><br>Services demonstrate that the use of restraint is actively minimised. | | continues to be restraint-free. There were no residents using enablers.<br><br>The restraint coordinator (clinical manager) reviews residents who may have behaviours that challenge, and these are discussed at the monthly quality meetings. Challenging behaviour and restraint minimisation and safe practice education is provided. |

# 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 1.3.3.4<br>The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach | PA Low | There is a care documentation policy including writing of progress notes in the electronic system. Direct cares are provided by caregivers, a worklog (ADL, position changes, food and fluid monitoring, skin management, toileting schedule) is created by the RNs for caregivers to complete. The worklog and progress notes are utilised to complete an RN daily or weekly review. The resident in the service apartments had daily progress notes from a caregiver and at least a weekly RN entry. When changes in a resident’s health care status is noted, it is expected caregivers’ complete information notes on the worklog; this is not always occurring for residents in the hospital and rest home. The clinical manager interviewed confirmed that staff were alerted of the shortfalls through toolbox meetings. The service commenced a quality improvement plan in June 2021 following an internal audit (sighted), however there were still shortfalls identified in the period following the commencement of corrective actions. | Two (one hospital and one rest home) of five residents progress notes did not evidence an accurate account of care | Ensure progress notes facilitate sharing of key information and readily highlight an emerging pattern of concern. |

| | | | | |
|---|---|---|---|---|
| where appropriate. | | | delivered. | 90 days |

# Specific results for criterion where a continuous improvement has been recorded

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

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

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

| No data to display |
|---|

End of the report.