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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Mayfair Lifecare (2008) Limited
Premises audited:	Mayfair Lifecare
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 19 March 2018 End date: 19 March 2018

Proposed changes to current services (if any): As per HealthCERT letter dated 12 August 2016 and 2 February 2017 a further eight rest home beds have been verified as part of this audit as suitable to provide dual-purpose care. This increases their dual-purpose beds from 37 to 45. The following is the mix with the increase in dual-purpose beds; in Cressy hospital wing there are 25 dual-purpose beds (including two double rooms), in Seymour hospital wing there are 13 dual-purpose beds and Randolph rest

home wing, there are 27 beds including 23 rest home only beds and four dual-purpose beds. In Charlotte Jane wing (serviced apartments), three of the 23 rooms have been verified as part of this audit to be utilised as dual-purpose.

Total beds occupied across all premises included in the audit on the first day of the audit: 70

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Mayfair Lifecare is owned and operated by the Arvida group. The service is certified to provide rest home and hospital (geriatric and medical) level care for up to 88 residents. There were 70 residents on the day of audit. The service is managed by a facility manager who is supported by a clinical manager. Residents and families interviewed commented positively on the standard of care and services provided at Mayfair Lifecare.

This surveillance audit was conducted against a subset of the Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, family, management and staff. This audit also included verifying a further eight rest home only rooms as suitable for dual-purpose. Of the eight rooms, three were in serviced apartments. All eight rooms have been verified as suitable to provide hospital or rest home level care.

Three of the four shortfalls identified as part of the previous certification audit have been addressed. These were around incident reporting, implementation of care and medication management. A further improvement continues to be required around care plan interventions.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.

The service has a culture of open disclosure. Families are regularly updated of residents' condition, including any acute changes or incidents. Complaints processes are implemented and managed in line with the Code. Residents and family interviewed verified ongoing involvement with the community.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.

Mayfair Lifecare is implementing a quality and risk management system that supports the provision of clinical care. Quality activities are conducted, which generates opportunities for improvement. Corrective actions are developed and implemented. There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

The registered nurses are responsible for each stage of service provision. The assessments and care plans are developed in consultation with the resident/family/whānau. The activity programme is varied and appropriate to the level of abilities of the residents. Medications are appropriately managed, stored, and administered with supporting documentation. Medication training and competencies are completed by all staff responsible for administering medicines. Food is prepared on-site with individual food preferences, dislikes and dietary requirements assessed by the registered nurses and a dietitian.

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 service displays a current building warrant of fitness.

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 service has policies and procedures to ensure that restraint is a last resort. Mayfair Lifecare has a restraint-free environment. Staff receives training in restraint minimisation.

Infection prevention and control

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

The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. The service implements effective outbreak management procedures. There have been no outbreaks since 2016.

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	16	0	0	1	0	0
Criteria	0	41	0	0	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The service has a complaints policy and procedure in place and residents and their family/whānau are provided with information on the complaints process on admission via the information pack. Complaint forms are available at each entrance of the services. Staff are aware of the complaints process and to whom they should direct complaints. A complaints register is available. Seven complaints (three in 2016, three in 2017 and one in 2018) have been received at Mayfair Lifecare since the last audit. The complaints reviewed had been managed appropriately with acknowledgement, investigations and responses recorded. Residents and family members advised that they are aware of the complaints procedure and how to access forms. An additional complaint made through the Health & Disability Commissioner (HDC) in 2017 has been investigated and followed up. An HDC letter received in February 2018 stated that no further action would be taken.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an	FA	Eight residents (five rest home and three hospital) interviewed, stated they were welcomed on entry and given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Ten incident/accidents had documented evidence of family notification or noted if family did not wish to be informed. Four relatives (three rest home and one hospital) interviewed, confirmed that they are notified of any changes in their family member's health status. Interpreter services are available as required.

environment conducive to effective communication.		
Standard 1.2.1: Governance 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 up to 88 residents including 23 serviced apartments certified to provide rest home level care. On the day of audit, there were 70 residents in total, 38 rest home including 11 in the serviced apartments and one respite rest home resident and 32 hospital residents including one in the serviced apartments and one respite hospital resident. There were originally 37 dual-purpose beds (four in the rest home wing and 33 across the two hospital wings). As per HealthCERT letter dated 12 August 2016 and 2 February 2017 a further eight rest home beds have been verified as part of this audit as suitable to provide dual-purpose care. This increases their dual-purpose beds from 37 to 45. The following is the mix with the increase in dual-purpose beds; in Cressy hospital wing there are 25 dual-purpose beds (including two double rooms), in Seymour hospital wing there are 13 dual-purpose beds and Randolph rest home wing, there are 27 beds including 23 rest home only beds and four dual-purpose beds. In Charlotte Jane wing (serviced apartments), three of the 23 rooms have been verified to be utilised as dual-purpose. The serviced apartment currently has a hospital resident that has been there for a number of years. The apartment is in close proximity to the nurse's station and the resident's needs are being met. There is a village manager who has been in the role since March 2017. He is supported by an experienced clinical manager who has been in the position since August 2017, having previously worked at another Arvida facility for five years. The village manager and clinical manager are supported by the general manager operations, general manager wellness and a national quality manager. The village manager reports to the general manager operations on a variety of operational issues and provides a monthly report. 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 for 2017–2018. Achievements against these plans are recorded on an action plan and are reviewed by the senior operations team at least annually. Regular meetings are held between the village manager and head office as well as weekly meetings between the village manager and clinical manager. The village manager and clinical manager have completed in excess of eight hours of professional development in the past twelve months.
Standard 1.2.3: Quality And Risk Management Systems	FA	There is a 2018 business/strategic plan that includes quality goals and risk management plans for Mayfair Lifecare. Interviews with staff confirmed that there is discussion about quality data at various staff meetings. The village manager is responsible for providing oversight of the quality programme on-site, which is also monitored at organisational level. The quality and risk management programme is designed to monitor contractual and standards compliance. The site-specific services policies are being transitioned over to the Arvida Group polices,

The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.		which will be reviewed at least every two years across the group. Head office sends new/updated policies. 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. The service has a health and safety management system that is regularly reviewed. Restraint and enabler use (which have not been used for over 9 months) is reviewed within the quality and clinical staff meetings. 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. Staff interviewed could describe the quality programme corrective action process. Health and safety goals are established and regularly reviewed. Risk management, hazard control and emergency policies and procedures are being implemented and are monitored by the Health and Safety Committee. The Health and Safety Committee has been recently changed to have more representative membership; six representatives have received specific health and safety training in their role. Hazard identification forms and a hazard register are in place. Resident/family meetings occur bi-monthly and resident and families interviewed confirmed this. Residents/relatives are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families. The overall service result for the resident/relative satisfaction survey completed in March 2017 was at 78%. Corrective actions were established in areas where improvements were identified, (i.e., around food/meals and activities). Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.
Standard 1.2.4: Adverse Event Reporting 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.	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. A registered nurse (RN) conducts clinical follow-up of residents. Ten incident forms (six hospital and four rest home) reviewed for February 2018, demonstrated that appropriate clinical follow-up and investigation occurred following incidents. Neurological observation forms were documented and completed for any unwitnessed falls. Two pressure injuries reviewed in February and March 2018 had incident forms completed and had been reported via the incident reporting process. This previous finding has now been addressed. Discussions with the village manager and clinical manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been five section 31 incident notifications completed since the last audit. Three notifications around pressure injuries, two unstageable pressure injuries, one in April 2017 and one in February 2018, and one stage three pressure injury in March 2018. One police investigation (missing persons) in February 2017 and one resident wandering in February 2018. An outbreak of norovirus in August 2016 was notified to the public health authorities.

Standard 1.2.7: Human Resource Management 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. This includes that the recruitment and staff selection process require that relevant checks are completed to validate the individual's qualifications, experience and veracity. Six staff files were reviewed (one clinical manager, one RN, three caregivers and one diversional therapist). 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 is kept. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Completed orientation is on files and staff described the orientation programme. The in-service education programme for 2017 has been completed and the plan for 2018 is being implemented. The village manager, clinical manager and RNs are able to attend external training, including sessions provided by the district health board (DHB). Discussions with the caregivers and the RNs confirmed that ongoing training is encouraged and supported by the service. Eight hours of staff development or in-service education has been provided annually. There are nine RNs and six of them have completed interRAI training.
Standard 1.2.8: Service Provider Availability 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 65 staff in various roles. Staffing rosters were sighted and there is staff on duty to match needs of different shifts. The village manager and clinical manager work 40 hours per week from Monday to Friday and are available on call after hours. In addition to the village manager and clinical manager, 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 confirm there are sufficient staff to meet the needs of residents. The caregivers interviewed stated that they have sufficient staffing levels. Across the two hospital wings (31 hospital residents and three rest home residents), there is one RN on duty on the morning and afternoon shifts, and one RN on the night shift. They are supported by six caregivers (three long and three short shifts) on the morning shift, four caregivers (two long and two short shifts) on the afternoon shift and two caregivers on the night shift. In the rest home area (23 rest home residents and one hospital), there is one RN on duty on the morning shift and one RN on the afternoon shift, the hospital RN cover the rest home on the night shift. They are supported by three caregivers (two long and one short shifts) on the morning shift, two caregivers (one long and one short shift) on the afternoon shift and one caregiver on the night shift. The serviced apartments (eleven rest home residents and one hospital resident) have a separate roster with one enrolled nurse (EN) on duty on the morning, supported by two caregivers on duty on the morning and the afternoon shifts. 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 including the hospital resident.

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	There are policies and procedures in place for safe medicine management that meet legislative requirements. The service has implemented an electronic medication system. Medications are administered by the registered nurses and medicine competent care givers Registered nurses and care staff interviewed were able to describe their role in regard to medicine administration. All medications are managed appropriately in line with required guidelines and legislation. Ten medication charts sampled met all the prescribing requirements. Each drug chart has a photo identification of the resident and allergies or nil known allergies are recorded on the medication chart. There were no self-medicating residents on the day of the audit. Internal medication audits are conducted monthly and six monthly. The medication charts reviewed identified that the GP had seen and reviewed the resident three monthly. The previous finding around warfarin prescribing has been addressed. Medications charts for three residents prescribed warfarin had documented INR reading and warfarin prescription chart which had been updated and signed by the GP when INR had been tested. The medication key was observed on the RN at all times during the audit.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	All meals at Mayfair Lifecare are prepared and cooked on-site. There are four weekly summer and winter menus with dietitian review. Meals are prepared in a well-appointed kitchen adjacent to the dining room for serving. Food is transported to the hospital residents in hot boxes and served immediately to residents. Kitchen staff are trained in safe food handling and food safety procedures are adhered to. There is food available for residents outside of meal times. Residents who require special eating aids are provided for, to promote independence. Resident dietary profiles and likes and dislikes are known to food services staff and any changes are communicated to the kitchen via the RN. A dietitian visits the service as required. Supplements are provided to residents with identified weight loss issues. Weights are monitored monthly or more frequently if required. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Interviews with residents and family members indicate satisfaction with the food service.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Moderate	Resident care plans reviewed were individualised, however care plans did not always document the specific care interventions required to meet all current assessed needs. Short-term care plans were in use for changes in health status and were evaluated on a regular basis and signed off as resolved or transferred to the long-term care plan. There was evidence of service integration with documented input from a range of specialists. Residents and family members interviewed confirm they are involved in the development and review of care plans. Previous findings around interventions and management of challenging behaviour remains an area to be improved. One resident had pain symptoms due to a fungating wound on the day of the audit. Care plan interventions for pain management has documented analgesia administered, but no nursing interventions to manage pain such as heat or

		cool pack. Registered nurses interviewed report nursing interventions prove futile for this resident as the area is very sensitive to touch. Staff interviewed were all aware of the pain the resident experiences, and to report symptoms to the registered nurse. There were no other residents with pain symptoms on the day of the audit. The medication chart indicated the use of as required and regular analgesia administered and GP has reviewed this resident symptom's regularly. All residents have a transfer and mobility plan completed by the physiotherapist which reflects current needs. There has been no restraint or enablers used in the last year. However, documentation around symptoms of hypoglycaemia remains an area for improvement.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	An electronic record of each resident's progress is documented. Changes are followed up by a RN (evidenced in all residents' progress notes sighted). When a resident's condition alters, the RN initiates a review and if required, a GP consultation or referral to the appropriate health professional is actioned. The caregivers interviewed advised that they have all the equipment referred to in care plans necessary to provide care. Dressing supplies are available and treatment rooms are well stocked for use. Wound documentation was reviewed and includes wound assessment, treatment plans and evaluations and progress notes. Advised that wound care nurse specialist advice is readily available. There were four wounds on the day of the audit which included skin tears, abrasions and one resident with a fungating wound. There were two stage three pressure injuries, one long-term resident and one respite resident. Sections 31 documentation had been completed for both. Dressing supplies are available and a treatment rooms are well stocked for use. Wound documentation was reviewed and includes wound assessment, treatment plans and evaluations and progress notes. Advised that wound care nurse specialist advice is readily available, and Nurse Maude wound care nurse had been involved with both pressure injuries. Continence products are available and specialist continence advice is available as needed. Short-term care plans are used for acute short-term changes in care. Monitoring charts were in use and examples sighted included (but not limited to), weight and vital signs, blood glucose, food and fluid, turning charts and behaviour monitoring as required. A physiotherapist is employed to assess and assist resident's mobility and transfer needs. The previous findings around residents who could not reach the call bell, have been addressed, residents observed in their rooms had their call bell at hand, or call bell could be accessed in communal areas. A pager system has been installed and there are regular call bell audits undertaken. There has been no restraint used in the facility for a year. All wound assessments, plans and evaluations are individual, and fully completed. The type of wound is identified, and all dressings are now completed by the registered nurse. Registered nurses have had wound care training. This is an improvement since the last audit.

Standard 1.3.7: Planned Activities 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	Mayfair activities team includes a wellness leader who is employed fulltime, a part time diversional therapist and activities coordinator. A large purpose-built room (the Gallery) is available for activities to take place and is well equipped. The wellness/activities staff at Mayfair provide an activities programme over five days per week. Group activities are voluntary and developed by the wellness/activities staff. Residents are able to participate in a range of activities that are appropriate to their cognitive and physical capabilities. Mayfair has its own van which is used for resident outings. The group activity plans are displayed on noticeboards around the facility. All residents who do not participate regularly in the group activities are visited by a member of the activity staff with records kept ensuring all such residents are included. All interactions observed on the day of the audit indicated a friendly relationship between residents and activity staff. The resident files reviewed included a section of the e-case care plan for activities and is reviewed six monthly. Residents interviewed spoke very positively of the activity programme with feedback and suggestions for activities made via the wellness and resident meetings and surveys.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Initial care plans are evaluated within three weeks of admission. In the files reviewed, interRAI assessments were completed and reviewed within expected timeframes. Long-term care plans were reviewed and evaluated at least six monthly by the RNs or when changes to care occur. The GP examines the residents and review the medications three monthly. Short-term care plans focus on acute and short-term needs. Interviews with residents and relatives confirm they are involved in care planning.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The service displays a current building warrant of fitness which expires on 1 August 2018. As per HealthCERT letter dated 12 August 2016 and 2 February 2017 a further eight rest home beds have been verified as suitable to provide dual-purpose care. This increases their dual-purpose beds to from 37 to 45. The following is the mix with the increase in dual-purpose beds; in Cressy hospital wing there are 25 dual-purpose beds (including two double rooms), in Seymour hospital wing there are 13 dual-purpose beds and Randolph rest home wing there are 27 beds including 23 rest home only beds and four hospital beds. In Charlotte Jane wing (serviced apartments), three of the 23 rooms have been verified to be utilised as dual-purpose. The serviced apartment currently has a hospital resident that has been there for a number of years. The apartment is in close proximity to the nurse's station and the resident's needs are being met. All the rooms dedicated for dual purpose are spacious, and provide enough room for the safe use of hoists, mobility aids and for the bed to be repositioned for manual handling requirements.

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	Infection surveillance and monitoring is an integral part of the infection control programme and is described in infection monitoring policy. A RN is the designated infection control nurse. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow-up, review and resolution. Surveillance of all infections are entered on to a monthly facility infection summary and staff are informed. This data is monitored and evaluated monthly and annually at facility and organisational level. An infection control team has been established for the purpose of monitoring infection rates, analysis of data and education and information for staff. Previous clinical improvement around reduction of urinary infections, through monitoring of hand hygiene and the use of personal protective equipment continue to be an ongoing focus of Mayfair Lifecare. The clinical manager reports following discussion at the clinical forum, the removal of “dipsticks” (urine test strips) have reduced the usage of antibiotics. Urinary tract infection rates continue to be low. An outbreak of norovirus in August 2016, which affected 40 residents and 14 staff was appropriately managed and reported to the DHB.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The service has documented systems in place to ensure the use of restraint is actively minimised. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. At the time of the audit there were no residents with restraints and no residents with an enabler and restraints have not been used for over 9 months... Staff received training on restraint minimisation in August 2017.

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 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	PA Moderate	All resident files reviewed had a care plan in place. All long-term care plans have mobility and transfer care plans, nutrition, management of activities of daily living were documented well. One resident with end of life care had a holistic care plan in place. Caregivers interviewed were able to describe the current care needs of the residents well. Care plan interventions for rest home residents described the care and support required. Shortfalls were identified in one hospital and two rest home care plans reviewed.	(i) There were no infection control interventions documented in the long-term care plan for a resident with MRSA in a wound, to guide caregivers on care of the wound during personal cares. Staff interviewed can describe the care and precautions required. (ii) There were no documented triggers and types of behaviours/anxiousness in the long-term care plan for a resident with challenging behaviours. These are recorded in the progress notes.	(i) Ensure infection control measures are documented in either a long or short-term care plan. (ii) Document the triggers, and behaviours displayed by residents in the long-term care plan.

			(iii) There was no information in the long-term care plan for caregivers to recognise symptoms of hypoglycaemia in a diabetic resident on insulin.	(iii) Ensure symptoms of hypoglycaemia are documented in care plans. 60 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.