Maygrove Rest Home Limited - Maygrove Lifecare

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Maygrove Rest Home Limited
Premises audited:	Maygrove Lifecare
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 29 March 2021 End date: 29 March 2021

Proposed changes to current services (if any): This provisional audit was undertaken to assess a prospective new provider's readiness to purchase and provide rest home services at Maygrove Lifecare.

Total beds occupied across all premises included in the audit on the first day of the audit: 40

Executive summary of the audit

Introduction

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

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

General overview of the audit

Maygrove Lifecare provides rest home care for up to 43 residents. The service is currently operated by Heritage Lifecare Group (HLL) and managed by a care home manager who is supported by a registered nurse. Residents and families spoke positively about the care provided.

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

This audit has resulted in one low risk area identified as requiring improvement relating to the condition of the shower rooms. Improvements have been made to recording care and care observations, addressing an area requiring improvement at the previous audit.

Consumer rights

Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Personal privacy, independence, individuality, and dignity are supported. Staff interact with residents in a respectful manner.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There was no evidence of abuse, neglect or discrimination.

The service has linkages with a range of specialist health care providers to support best practice and meet resident's needs.

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

Organisational management

NZACS has a documented transition plan which was reviewed and discussed during interview. This provides timeframes and staged steps for processing all the matters necessary for acquiring the facility and its operations. The NZACS team demonstrated knowledge and understanding about all the requirements for delivering residential rest home care to older people under NZ legislation, these standards and funding agreements. They plan to continue using the already established quality, risk and human resources systems in place as agreed by the current owners.

Business and quality and risk management plans included the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body was regular and effective and occurs via key performance indicator reporting. An experienced and suitably qualified person manages the facility.

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

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

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

Continuum of service delivery

Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission.

The service is managed by the care home manager Monday to Friday who is supported by an experienced registered nurse. Care staff cover twenty-four hours a day, seven days a week. On call arrangements for support from senior staff are in place. Shift handovers and communication sheets guide continuity of care. Care plans are individualised, based on a comprehensive range of information and short-term care plans are developed to manage any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

Residents and families interviewed reported being kept well informed and involved in care planning and evaluation, and that care is of a high standard.

The planned activity programme provides residents with a variety of individual and group activities and maintains strong links with the community.

Medicines are safely managed using an electronic system 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 verified satisfaction with meals.

Safe and appropriate environment

The facility is configured using a traditional design and meets the needs of residents. It was clean and well maintained, with the exception of the kitchen and shower rooms which require some refurbishment. There was a current building warrant of fitness. Electrical equipment has been tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. The storage and use of personal protective equipment has been reviewed and increased as a result of the Coronavirus. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite and residents reported satisfaction with laundry processes.

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

Restraint minimisation and safe practice

The organisation has implemented policies and procedures that support a policy of no-restraint use. No enablers or restraints were in use at the time of audit, and this had been the case for some time.

Infection prevention and control

The infection prevention and control programme, led by an experienced and trained registered nurse who is the infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed from the DHB when needed such as during the recent Covid-19 pandemic.

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

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

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	44	0	1	0	0	0
Criteria	0	92	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)
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 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Heritage Lifecare Group (HLL) has provided Maygrove Lifecare with policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	The registered nurse and caregivers interviewed understand the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Residents' records showed that informed consent has been gained appropriately using the Heritage Lifecare Limited standard informed consent form including consent to be photographed for medical records and recreational activities, consent for outings, infection screening if required, and for the

		exchange of medical information between the GP, other health professionals and Maygrove Lifecare. Advance directives/advance care planning, establishing and documenting enduring power of attorney (EPOA) requirements and processes for residents unable to consent is defined and documented where relevant in the resident`s record. Staff demonstrated their understanding by being able to explain when this may occur. Staff were observed to gain consent for day-to-day care on an ongoing basis and residents interviewed confirmed this occurs.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	During the admission process, residents are given a copy of the Code, which also includes information on the advocacy service. Posters and brochures related to the advocacy service were also displayed and available in the facility. Family members and residents spoken with were aware of their rights and of the advocacy service, how to access this and their right to have support persons. Staff interviewed were aware of how to access the advocacy service and were able to describe when this might occur.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. At the time of audit, a group of residents attended a lunch club in the community. Individual residents were observed to leave the facility to go on outings with family or to the shops. Evaluation of activities occurs to confirm residents' needs are met. The facility has unrestricted visiting hours and encourages visits from residents' families and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.
Standard 1.1.13: Complaints Management	FA	Information on the complaint process is provided to residents and

The right of the consumer to make a complaint is understood, respected, and upheld.		families on admission and those interviewed knew how to make a complaint. The complaints register reviewed showed that five complaints had been received in 2020, and one minor concern had been received to date in 2021. Actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans show any required follow up and improvements have been made where possible. The care home manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Residents interviewed reported being aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) through conversations with staff and as part of the admission information provided when residents are provided with a copy of the Heritage Lifecare resident 'Code of Rights'. The Code is displayed in reception area and includes information on advocacy services, how to make a complaint and feedback forms. The prospective purchaser is aware of the consumer rights that it must adhere to.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality, and choices. Staff interviewed understood the need for privacy and were observed to maintain privacy throughout the audit. All residents have a private room or share a room with their spouse with their consent. Residents are encouraged to maintain their independence by attending community activities such as church services and a community lunch club, arranging their own visits to the doctor, participation in clubs of their choosing. Residents are involved in the care of the garden growing vegetables and flowers which are enjoyed by all. Care plans included documentation related to the resident's abilities, and

		strategies to maximise independence. Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan. Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	Staff support residents in the service who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau. There is a current Māori health policy developed with input from cultural advisers. Guidance on tikanga best practice is available. A Māori resident and her whānau interviewed reported that staff acknowledged and respected her individual cultural needs, they stated the facility had been chosen for permanent care following a period of respite when her needs were fully met.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences, required interventions and special needs were included in care plans reviewed, for example residents who wished to attend church services in the community and/or a non-denominational service which are held in the facility and a resident whose cultural requirements for food were documented and met. The resident satisfaction survey confirmed that individual needs are being met.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. The registered nurse has completed the required training on professional boundaries. Staff are guided by policies and procedures

		and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example; community pharmacist, District Health Board (DHB) infection prevention and control nurse, wound care specialist, and mental health services for older persons, and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests. She described the staff as being very good, she had complete trust in their clinical ability and stated they understood the needs of the residents well. Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice. Other examples of good practice observed during the audit included care plans which guide caregivers clearly in relation to monitoring medical conditions, the collaboration with the community pharmacist to review resident medications, the introduction of the palliative outcomes initiative (POI) pathway and a vibrant and diverse activities programme.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents and family members stated they were kept well informed about any changes to their or their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was evident in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. Staff knew how to access interpreter services, although reported this was rarely required due to staff able to provide interpretation as and when needed and the use of family members.

Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	The Heritage Lifecare Limited (HLL) business plan is active at Maygrove Lifecare. The HLL documents describe annual and long term objectives and Maygrove's care home manager reports against these. A small sample of reports were reviewed (because the care home manager has only been in the position for a month), which go to the support office and are monitored by the regional operations manager and the quality assurance lead and team. The reports sighted showed adequate information to monitor performance is reported including financial performance, health and safety compliance, occupancy, staffing, any emerging risks and clinical issues. The service is managed by a care home manager who holds relevant qualifications and has been in the role for about one month. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The care home manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through an ongoing commitment to professional development. The service holds contracts with Waitemata DHB for rest home care and long-term care for chronic health conditions. All residents are receiving care under the rest home contract at the time of audit. Prospective New Provider Interview: The new provider (NZ Aged Care Services Ltd T/A Maygrove Rest Home) is an established New Zealand aged care provider, with its principals having been involved in aged care service delivery since the 1990's. A transition plan has been drafted and is in the process of being operationalised. This includes provision of infrastructure support such as providing information technology capability including hardware and software. It is expected that the senior team will remain in place at Maygrove Lifecare. It is expected that existing staff will transfer to the new provider. The prospective purchaser has notified the relevant DHB of the intended sale sometime before this provisional audit being undertaken.

Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	FA	When the care home manager is absent, the registered nurse (RN) carries out all the required duties under delegated authority. During absences of key clinical staff, a newly appointed additional 0.8FTE registered nurse with a current practicing certificate and who is experienced in the sector is to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well. New Provider Interview: The prospective provider is not planning any staffing changes. Existing cover arrangements for the day-to-day operations will remain in place, with access to a regional operations manager. The prospective new owner understands the needs of aged care services and understands the Age Residential Related Care (ARRC) agreement, including in relation to responsibilities of the ARRC manager to meet section D17 of the agreement.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, an annual resident and family satisfaction survey, monitoring of outcomes, and clinical incidents including infections. There is a Quality and Risk Management plan that covers the two-year period from 2018 to 2020, but this is yet to be updated and confirmed for 2021. Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the staff meetings. Staff meetings fulfil the function of quality and risk meeting, health and safety meeting and infection control meeting. Staff reported their involvement in quality and risk management activities through audit activities, and involvement in staff meetings. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. The most recent survey (July 2020) showed a high level of satisfaction with services provided. There is a planned audit schedule for 2021 (about six internal audits scheduled to occur each month); the due audits for 2021 to date have

		been comprehensively completed by the care home manager or the registered nurse. The care home manager described the processes for the identification, monitoring, review and reporting of risks and development of any mitigation strategies if required. The care home manager is familiar with the Health and Safety at Work Act (2015). Prospective New Owner Interview: The prospective new owner states that the policies and procedures will remain the same once the sale is confirmed. The prospective new owner states that reporting using the HLL framework will remain the same but with reporting occurring to the new company's support office, rather than to the HLL support office. A new regional operations manager has been employed and will be available to support the transition process.
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	Staff document adverse and near miss events on an accident/incident form according to organisational policies and procedures on adverse event reporting. A sample of incident forms reviewed showed these were fully completed, incidents were investigated, action plans developed, and actions are followed-up in a timely manner. Adverse event data is collated, categorised, analysed and reported to support office level via the regional operations manager. Quality and risk meeting minutes for Maygrove Lifecare include summaries of these processes, any trends identified and any recommended corrective action or quality improvement follow-up. Information resulting from these analyses is shared with staff who confirmed during interview that they understand the information provided and find the updates useful. Secftion 31 notifications had been made to the Ministry of Health where required. There have been no health and disability complaints, or other significant events, since the previous audit. New Provider Interview: There are no known legislative or compliance issues impacting on the service. The prospective owner is aware of all current health and

		safety legislative requirements and the need to comply with these.
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	Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained. A spreadsheet monitors the currency of annual practicing certificates for employed health professionals (the RN), plus externally contracted health professionals including the GPs, podiatrist, physiotherapist, pharmacists, and dietitians. These are all confirmed as current. Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation. Continuing education is planned on an annual basis, including mandatory training requirements. In 2021, about six to eight sessions each month are planned. Training was disrupted during 2020 due to Covid-19, but even so, several training sessions took place including mandatory training and an emphasis on infection prevention and control. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. The full-time registered nurse plus an additional casual registered nurse are both assessed and signed off as interRAI competent. The newly appointed RN (who is yet to commence her work at Maygrove) is also interRAI trained and assessed as competent. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from	FA	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). A separate rostering policy details

suitably qualified/skilled and/or experienced service providers.		these requirements at the facility level. The care home manager reported that staffing levels are altered in order to meet the changing needs of residents. The registered nurse works Sunday to Thursday. The newly appointed RN will work Wednesday to Saturday and they will share 'on call' responsibilities. This ensures there is 24/7 on call RN cover. Caregivers reported during interview that there is good access to advice when needed. Observations and review of four previous weeks of the roster, the current week plus one week going forward confirmed adequate staff cover is provided, with staff replaced in any unplanned absence; this was also confirmed by manager and staff interview. There are routinely four caregivers rostered on a whole or part of the morning shift, three on all or part of the afternoon shift, and two caregivers overnight. During the day (Monday to Friday) there is also the care home manager, the RN (Sunday to Thursday), the activities coordinator, a cleaner, a laundry person, a cook, a kitchen hand, the maintenance officer (4 days per week) and an administrator. The roster now notes the designated first aider who is rostered on for each shift. Agency staff are used as a last resort only for RNs and had been used only during February (four shifts) and March (two shifts), as with the transfer of the care home manager to another facility, there was only one RN available at Maygrove during this period. Analysis of call bell response times is monitored using the electronic call bell system. This shows that in 99% of cases, call bells are answered within one minute, with isolated cases of call bells remaining on for two to three minutes. No longer wait times were noted. New Provider Interview: The prospective owner intends to maintain the current staffing levels and skill mix. The prospective new owner interviewed was able to confirm understanding of the required skill mix to ensure rest home residents' needs are met.

Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable. Archived records are held securely on site and are readily retrievable using a cataloguing system. Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and to meet with the care home manager and registered nurse. They are provided with written information about the service and the admission process. The organisation seeks updated information from the Needs Assessment and Service Coordination service (NASC), GP and/or family for residents accessing respite care. Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB's 'yellow envelope' system to facilitate transfer of resident information to and from acute care services. There is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information, including the

		medication records, copy of the enduring power of attorney (EPOA), advance directives or resuscitation status forms is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient transferred to the local hospital showed information necessary to inform the receiving health care provider was sent with the resident. The resident reported being kept well informed during the transfer.
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	The medication management policy was current and identified all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The registered nurse checks the medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request and a community pharmacist visits to review residents' medications. Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries. The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range. Prescribing practices included the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines. The required three-monthly GP review was consistently recorded on the medicine chart. Verbal and standing orders are not used. There are no residents who were self-administering medications at the

		time of audit. Appropriate processes were in place to ensure this was managed in a safe manner and the registered nurse interviewed was able to describe the process to be followed, including resident assessment, education and medication storage should this occur. Medication errors are reported to the registered nurse and recorded on an incident form. There is an implemented process for comprehensive analysis of any medication errors and feedback to staff is provided.
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	The food service is provided on site by a qualified cook and a team of kitchen assistants. It is 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. Recommendations made at that time have been implemented. 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 issued by Auckland Council. Food temperatures, including for high-risk items, are monitored appropriately and recorded as part of the plan. The food services manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training. A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special occasions, such as birthdays, are celebrated and catered for. Evidence of resident satisfaction with meals was verified by resident and family interviews and satisfaction surveys. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and staff are available to assist residents as required.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk	FA	If a referral is received but the prospective resident does not meet the entry criteria or there is no vacancy, the local NASC is advised to

to the consumer and/or their family/whānau is managed by the organisation, where appropriate.		ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed. There is a clause in the access agreement related to when a resident's placement can be terminated.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Information is documented using validated nursing assessment tools including pain scale, falls risk, skin integrity, nutritional screening, cognitive screening, a physiotherapy assessment and an activities assessment as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. Residents have current interRAI assessments completed and the relevant outcome scores have supported care plan goals and interventions. The facility is waiting for the transfer of one resident's file in order to complete the interRAI assessment. Until this time the resident's care plans are based on admission information and the range of assessments detailed above. Residents and families confirmed their involvement in the assessment process.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Care plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed and detailed interventions sufficient to inform caregivers on the needs of each resident. Care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. This was confirmed by observation, interview and review of resident files. Residents and families reported participation in the development and

		ongoing evaluation of care plans.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Documentation, observations and interviews verified that care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. Caregivers interviewed confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the rest home level of care provided and in accordance with the residents' needs.
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	The activities programme is provided by an activities coordinator who has been in the role for over two years. A social assessment and history are undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated three monthly and as part of the formal six-monthly care plan review. The planned activity programme sighted reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular outings or events are offered. Examples include chair exercises, ten pin bowling, bingo, bible study and non-denominational church services, van outings, shopping trips to the local supermarket and a lunch club with other aged care facilities in the area. Residents were also observed to participate in individual activities such as embroidery, gardening and board games. Evaluation of individual activities and review of attendance occurs to maintain a varied programme that meets the residents' changing interests. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings and satisfaction

		surveys. Residents interviewed confirmed they find the programme varied and interesting.
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 notes. If any change is noted, it is reported to the registered nurse. Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care, examples of this were seen in the files reviewed. Examples of short-term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted for infections and wound care. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a resident contracted doctor, residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP sends a referral to seek specialist advice/input. Copies of referrals were sighted in resident`s records, including to speech language therapists, dietitians and specialist medical services at Waitemata DHB. Any acute/urgent referrals are attended to immediately, such as sending the resident to the local emergency centre for assessment and treatment; the registered nurses described examples of when this might occur.
Standard 1.4.1: Management Of Waste And Hazardous Substances	FA	Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. An external company is contracted to

Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.		supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur. There is provision and availability of protective clothing and equipment and staff were observed using this. The storage and supply of personal protective equipment (PPE) had been reviewed and increased as a result of Covid-19, and staff had received extra training in relation to the correct donning and doffing of PPE.
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 2021) was displayed in the entrance. Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment was current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. The environment was hazard free and resident safety was promoted. External areas are safely maintained and were appropriate to the resident group and setting. Staff confirmed they know the processes they should follow if any repairs or maintenance are required and that requests are actioned. Residents and family members were happy with the environment. Prospective new provider interview: The prospective new owner confirms that there are no plans to change the environment. They are aware of the remedial maintenance work required in the shower rooms (refer 1.4.3).
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to	PA Low	There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. All rooms have an ensuite toilet and vanity. Additionally, there are five shower rooms spread throughout the facility, two of which are in need of repair as the linoleum on the

personal hygiene requirements or receiving assistance with personal hygiene requirements.		coving is cracked and could pose an infection risk. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	All bedrooms provide single accommodation with the exception of one room which is split into two and is shared by a married couple. All rooms have an ensuite toilet, and whilst small, do provide room for a single bed, wardrobe, and a set of drawers. Rooms are personalised with furnishings, photos and other personal items displayed.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	Communal areas are available for residents to engage in recreation, relaxation and activities. There are two adjacent dining areas and three lounge areas across the facility, which are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	Laundry is undertaken on site in a dedicated laundry. Dedicated laundry staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner. The cleaning team have received appropriate training. Chemicals were stored either in a lockable cupboard or in a manner that was secure and were in appropriately labelled containers. Cleaning and laundry processes are monitored through the internal audit programme. The home was noted to be clean and tidy and free from malodour on the days of audit.
Standard 1.4.7: Essential, Emergency, And Security Systems	FA	Policies and guidelines for emergency planning, preparation and

Consumers receive an appropriate and timely response during emergency and security situations.		response were displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan has been approved by the New Zealand Fire Service for many years and no changes have been made to the service to trigger a new approval to be needed. A trial evacuation takes place six-monthly and has been undertaken most recently in November 2020. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures. There are processes in place to ensure a trained and certified first aider is available on each shift. Adequate supplies for use in the event of a civil defence emergency, including food, water, mobile phones and gas BBQ's were sighted and meet The National Emergency Management Agency recommendations for the region. Water storage tanks and bottles are located around the complex, and there is a generator on site. Call bells alert staff to residents requiring assistance. The electronic call system provides an easy audit function and r4eview of the system determines that call bells are responded to promptly. Appropriate security arrangements are in place.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light and opening external windows. Heating is provided by wall heaters in residents' rooms in heat pumps the communal areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall	FA	The service implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, developed at an organisational level with

be appropriate to the size and scope of the service.		input from infection prevention and control advisors. The infection control programme and manual are reviewed annually. The registered nurse is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the care home manager, and tabled at the quality and staff meeting monthly. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities. Signage at the main entrance to the facility includes information related to the Covid-19 pandemic and requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. Hand hygiene and contact tracing information is available.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The IPC coordinator has appropriate skills, knowledge and qualifications for the role, and has been in this role for over ten years. She has undertaken education in infection prevention and control and attended relevant study days, as verified in training records sighted. Additional support and information are accessed from the infection control team at the DHB, the community laboratory, the GP and Heritage Lifecare Limited as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections. The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection. Appropriate supplies to manage an outbreak of Covid-19 were available and plans identified should residents require isolation.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures	FA	The infection prevention and control policies, developed at an organisational level, reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in 2019 and included appropriate referencing.

are practical, safe, and appropriate/suitable for the type of service provided.		Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers were readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Interviews, observation and documentation verified staff have received education on infection prevention and control at orientation and ongoing education sessions. Education is provided by the IPC coordinator and online. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When an infection outbreak or an increase in infection incidence has occurred, there was evidence that additional staff education has been provided in response. An example of this occurred in response to the Covid-19 pandemic with education provided on hand hygiene, donning and doffing personal protective equipment and isolation procedures. Education with residents is generally on a one-to-one basis and has included reminders about personal hygiene, handwashing, and advice about remaining in their room if they are unwell.
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, soft tissue, fungal, eye, gastro-intestinal, and the upper and lower respiratory tract. The IPC coordinator reviews all reported infections and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the organisational operations manager. Data is

		benchmarked externally within the group. Benchmarking has allowed monitoring of targets to reduce infections and provided assurance that infection rates in the facility have decreased to meet the target set.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The registered nurse is the restraint coordinator and provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities. On the day of audit, no residents were using restraints or enablers, and this had evidently been the case for some time. Staff interview confirmed that Maygrove Lifecare is a restraint free environment.

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 1.4.3.1 There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of consumers. This excludes any toilets/showers/bathing facilities designated for service providers or visitor use.	PA Low	There are five shower rooms available for resident use. The upstairs shower room is fairly new and in good repair. One of the shower rooms in the downstairs wings had been recently renovated but the others remain older and darker. In two of the shower rooms, the lino is cracked, and this poses an infection risk. In one shower room the mould that was identified at the last audit (October 2020) had been removed as the shower room had undergone a deep clean.	Three of the shower rooms are showing signs of need for repair. The lino is cracked, and this poses an infection risk.	Plan and implement a remedial process that addresses the condition of the shower rooms. 180 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.