Elms Court Lifecare Limited - Maidstone 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 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:	Elms Court Lifecare Limited
Premises audited:	Maidstone Lifecare
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 28 November 2018 End date: 29 November 2018

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 19

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.

General overview of the audit

Maidstone Hospital is part of the Heritage Lifecare (BPA) Limited group. The service provides care for up to 32 rest home and hospital (geriatric and medical) level care residents. At the time of the audit there were 19 residents in total.

The service is currently being managed by the Heritage Lifecare operations manager and a Heritage Life care relief manager. There is an experienced a full-time clinical services manager (RN) who has been in the role for two years.

A provisional audit was conducted to assess a prospective new owner for Maidstone Hospital and to assess the status of the service prior to purchase. This audit was conducted against the health and disability service standards and the district health board contract. The audit process included a review of existing policies and procedures, the review of resident and staff files, observations and interviews with residents, family members, staff and management.

This provisional audit included an interview with the prospective owner. The prospective owner currently owns one other aged care facility and has policies and processes in place around the understanding of consumer rights. The prospective owner stated that the clinical services manager will stay in the role with support from the prospective owner as facility manager. New clinical systems, policies and procedures will be introduced. There will be no other changes to staff. The new owner intents to build an onsite laundry.

The provisional audit identified areas for improvement around; the need for a documented transition plan, laundry services provision, quality meeting documentation, and monitoring charts.

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 facility provides care in a way that focuses on the individual resident. The service functions in a way that complies with the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and related services is readily available to residents and families. Policies are available that support residents' rights. Care plans accommodate the choices of residents and/or their family. Complaints processes are being implemented and complaints and concerns are managed and documented. Residents and family interviewed, verified ongoing involvement with community.

Organisational management

The service is managed by a clinical services manager who has worked in the role for the two years. She is supported by an operations manager, a relief manager, registered nurses and other care staff. Business plan objectives/goals provide direction. The quality management system is being implemented. Quality activities are conducted, which generate improvements in practice

and service delivery. Meetings are held to discuss quality management processes. Residents' meetings are held, and residents and families are surveyed annually. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported. An annual education and training schedule is in place. There are job descriptions for all positions that include the role and responsibilities of the position. There is a roster that reflects sufficient and appropriate coverage for the effective delivery of care and support.

Continuum of service delivery

The service has assessment processes and residents' needs are assessed prior to entry. There is an admission pack available for residents and families/whānau at entry. Assessments, resident care plans, and evaluations were completed by the registered nurses within the required timeframes. Risk assessment tools and monitoring forms were available and implemented. Resident care plans were individualised and included allied health professional involvement in resident care. The activities coordinator implements the activity programme to meet the individual needs, preferences and abilities of the residents. Community links are maintained. There are a variety of activities that are meaningful to the residents. There are medicine management policies in place that meet legislative requirements. Staff responsible for the administration of medications complete annual medication competencies and education. Medication charts have photo identification and allergy status noted. Medication charts are reviewed three monthly by the general practitioner. All food and baking is done onsite. Resident's individual dietary needs were identified and accommodated. Staff have attended food safety and hygiene training.

Safe and appropriate environment

There were documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Chemicals were stored safely throughout the facility. The building has a current warrant of fitness. Resident rooms and bathroom facilities are spacious. There is plenty of natural light in all rooms and the environment is comfortable with adequate ventilation and heating. All communal areas within the facility are easily accessible. The outdoor areas are safe and easily accessible and provide seating and shade. The service has implemented policies and procedures for civil defence and other emergencies and six-monthly fire drills are conducted. There is one person on duty at all times with a current first aid certificate.

Housekeeping/laundry staff maintain a clean and tidy environment. Documented policies and procedures for the cleaning and laundry services are implemented with monitoring systems in place to evaluate the effectiveness of these services. The laundry is done off-site at another Heritage Lifecare facility. The new owner plans to develop a laundry within the facility.

Restraint minimisation and safe practice

Maidstone Hospital has restraint minimisation and safe practice policies and procedures in place. At the time of the audit there were no residents using restraints and two residents using an enabler. Resident files reviewed of residents with restraint evidenced a restraint risk assessment, consent form and three-monthly evaluations. Staff receive training in restraint minimisation.

Infection prevention and control

The infection control programme is appropriate for the size and complexity of the service. The infection control coordinator (registered nurse) is responsible for coordinating and providing education and training for staff. The infection control coordinator has attended external training. The infection control manual outlined the scope of the programme and included a range of policies and guidelines. Surveillance data is collected and collated. The infection control officer uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This included audits of the facility, hand hygiene and surveillance of infection control events and infections.

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	41	0	4	0	0	0
Criteria	0	89	0	4	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	Discussions with eight staff (three caregivers, two registered nurses, the kitchen manager, the maintenance person and the activities person) confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Seven residents (three rest home and four hospital) and one hospital level relative were interviewed and confirmed the services being provided are in line with the Code. Observation during the audit confirmed this in practice. The prospective owner currently owns one other aged care facility and has policies and processes in place around the understanding of consumer rights.
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	An informed consent policy is implemented. Systems are in place to ensure residents, and where appropriate their family/whānau, are provided with appropriate information to make informed choices and informed decisions. The caregivers interviewed demonstrated a good understanding in relation to informed consent and informed consent

		processes. Residents interviewed confirmed they have been made aware of and fully understand informed consent processes and that appropriate information had been provided. Five long-term resident files reviewed had signed admission agreements.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Residents are provided with a copy of the Code on entry to the service. Residents interviewed, confirmed they are aware of their right to access independent advocacy services and advocacy pamphlets are available at reception. Discussions with a relative and RNs confirmed the service provides opportunities for the family/enduring power of attorney (EPOA) to be involved in decisions. The resident files include information on residents' family/whānau and chosen social networks.
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 and a relative interviewed, confirmed open visiting. Activities programmes include opportunities to attend events outside of the facility including activities of daily living, for example, shopping and attending cafés, and restaurants. Interview with staff, residents and a relative, informed that residents are supported and encouraged to remain involved in the community and external groups. Relatives and friends are encouraged to be involved with the service and care.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	A complaints policy and procedures have been implemented and residents and their family/whānau have been provided with information on admission. Complaint forms are available at the entrance of the service. Staff are aware of the complaints process and to whom they should direct complaints. A complaints register is documented with one complaint since the previous audit. This complaint was documented as followed-up to the satisfaction of the complainant. Residents and a family member advised that they are aware of the complaints procedure and how to access forms.

Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	The service provides information to residents that include the Code, complaints and advocacy. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Residents and relatives interviewed identified they are well informed about the Code. Two monthly resident meetings provide the opportunity to raise concerns. An annual residents/relatives' satisfaction survey was in the process of completion at the time of audit.
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	Staff interviewed could describe the procedures for maintaining confidentiality of resident records, resident's privacy and dignity. A code of conduct is signed by staff at commencement of employment and by existing staff when the service was previously bought by Heritage Lifecare (BPA) Limited in April 2018. Residents and relatives interviewed reported that residents can choose to engage in activities and access community resources. There is an elder abuse and neglect policy and staff education and training on abuse and neglect has last been provided.
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	There is a Māori health plan and ethnicity awareness policy and procedure. The policy includes references to other Māori providers available and interpreter services. The Māori health plan identifies the importance of whānau. At the time of audit there were no residents that identified as Māori. Staff interviewed confirmed they are aware of the need to respond appropriately to maintain cultural safety. Staff training around The Treaty of Waitangi and cultural care has last been provided in May 2018.
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	An initial care planning meeting is carried out where the resident and/or whānau as appropriate/able are invited to be involved. Individual beliefs or values are further discussed and incorporated into the care plan. Discussion with a relative confirmed values and beliefs are considered. Residents interviewed confirmed that staff consider their culture and values.

Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Staff job descriptions include responsibilities, and staff sign a copy on employment. The staff meetings occur monthly and have included discussions on professional boundaries and concerns as they arise. Training was provided May 2018. Management provide guidelines and mentoring for specific situations. Interviews with the clinical services manager, RNs and caregivers confirmed an awareness of professional boundaries.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The clinical services manager, and staff are committed to providing services of a high standard, based on the service philosophy of care. All residents and families interviewed spoke positively about the care and support provided. Monthly staff and two monthly residents' meetings are conducted. Staff have a good understanding of principles of aged care and stated that they feel supported by management. Care staff complete competencies relevant to their practice. The quality programme has been designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Staffing policies include pre-employment, and the requirement to attend orientation and ongoing in-service training.
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 welcomed on entry and were given time and explanation about services and procedures. The family members interviewed also stated they are informed of changes in the health status of residents and incidents/accidents, and five incident forms reviewed confirmed this. Resident/relative meetings are held two monthly. The clinical services manager and operations manager have an open-door policy. The service has policies and procedures available for access to interpreter services for residents (and their family/whānau). If residents or family/whānau have difficulty with written or spoken English, the interpreter services are made available.

Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	PA Low	Maidstone Hospital is part of the Heritage Lifecare (BPA) Limited. The service provides care for up to 32 rest home and hospital (geriatric and medical) level care residents. At the time of the audit there were 19 residents in total. All the beds are dual-service beds. On the day of audit there were six rest home residents, including one resident funded under the serious medical illness contract (SMI). There were 13 hospital residents including; one ACC funded resident and one SMI funded resident. All other residents were under the age-related residential care (ARRC) contract. The service is currently being managed by the Heritage Lifecare operations manager and a Heritage relief manager. There is an experienced full-time clinical services manager (RN) who has been in the role for two years. A monthly and weekly report is provided to the operations manager on all aspects of service delivery. There is a business plan covering 2018 and 2019, which identifies business objectives/goals. A review of the business objectives/goals has been completed annually. This provisional audit included an interview with the prospective owner. The prospective owner currently owns one other aged care facility and has owned this facility for eight years. The prospective owner will become the facility manager with clinical oversight by the currently clinical services manager. The prospective owner plans to introduce new policies and procedures and quality system at Maidstone. These are currently in use at his other facility and there is intention to change the laundry process. There is no transition plan documented. The prospective new owner will continue current memberships with established professional bodies.
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	The operations manager and relief manager provide cover during a temporary absence of the facility manager, with the support from the clinical services manager. The prospective owners stated the clinical services manager will cover during a temporary absence of the facility manager, with the support from registered nurses.

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.	PA Low	Maidstone Hospital has a documented quality management system. There are policies and procedures implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. The service has in place a range of policies and procedures to support service delivery that are developed through the Heritage Lifecare head office. Staff interviewed confirmed they are made aware of new/reviewed policies. Quality data trends analysis related to incident and accidents, and infection control, are collected. There are monthly adverse event reports (accident/incident data) provided around falls, skin tears, pressure injuries and medication error incidents. There is an internal audit schedule in place, although internal audits had not all been completed as scheduled. Corrective action plans were developed, implemented and signed off for any improvements identified. Quality improvement processes are in place to capture and manage non-compliances. They include internal audits, hazard management, risk management, incident and accident and infection control data collection and complaints management. Quality improvement data is discussed at monthly quality meetings and issues identified and followed up. Meeting minutes reviewed, included discussion around; current maintenance issues, incidents and accidents, health and safety, infection control, complaints, internal audits and quality goals. Meeting minutes did not always document follow-up and closure of issues raised. There are two monthly residents' meetings conducted and families are invited to attend. The annual survey is currently in process. A health and safety programme is in place that meets legislative requirements. Health and safety is discussed at the monthly quality meetings. There is an up-to-date hazard identification and control register in place that is reviewed as part of the quality meetings. Falls prevention strategies are in place that include the analysis of falls incidents, sensor mats for relevant residents and the identification of interventions on a case-by-case basis to minimise future falls. The prospective new owner will introduce new systems, including the quality process and procedures in place at his current facility (link to

		1.2.1.1).
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	The service collects incident and accident data and reports aggregated figures monthly to the quality meetings. Staff interviewed confirmed that incidents and accidents were discussed with them. Five incident forms reviewed from October 2018, demonstrated that appropriate clinical follow-up and investigation occurred following incidents. Neurological observation forms were documented and completed for four unwitnessed falls with a potential head injury. Discussions with the clinical services manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been no section 31 incident notifications completed since the last audit. There have been no outbreaks.
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	Recruitment policy and procedures describes the appointment process. Six staff files selected for review (one clinical services manager, one RN, three caregivers and one cook) included evidence of the recruitment process including police vetting, signed employment contracts, job descriptions and reference checks. In addition, all staff files reviewed documented a new police check, contract of employment and job description for when Heritage Lifecare became the owner. The orientation package provides information and skills around working with residents with rest home and hospital level care needs. All care staff files documented a Heritage Lifecare orientation. Staff interviewed stated that new staff are adequately orientated to the service. There is an annual in-service education and training calendar schedule, which includes all mandatory subjects the training had been provided as per plan, and provided more than eight hours annually for staff. There are nine RNs (including the clinical services manager) and six have completed interRAI training. Medication competencies are up-to-date. Current annual practising certificates were sighted for the registered health professionals.

Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	There is a documented rationale for staffing the service. On the day of audit there were 19 residents in total (6 rest home and 13 hospital). The clinical services manager works full time from Monday to Friday and is available 24/7 for any operational and clinical issues. The roster included; A registered nurse for each shift Three caregivers (two long shifts and one short shift) for the AM shift and for the PM shift. One caregiver at night. Staff, residents and family members interviewed reported there are sufficient staff numbers and that management are accessible. The prospective owner stated there will be no changes to the roster and staff, who will transfer to the new owner on the date of settlement.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Other residents or members of the public cannot view sensitive resident information. Resident files are protected from unauthorised access by being held in a locked office. Care plans and notes were legible and where necessary signed (and dated) by a RN.
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	The service has admission policies and processes in place. Residents receive an information pack outlining services provided, the admission process and entry to the service. The clinical services manager screens all potential residents prior to entry and records all admission enquires in a hard copy system. Residents and a relative interviewed, confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the nurse manager. Five admission agreements in use align with the requirements of the ARRC contract.

Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Planned exits, discharges or transfers are coordinated in collaboration with the resident and family to ensure continuity of care. There are documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The yellow envelope system is used for transfers to the public hospital. A transfer form accompanies residents to receiving facilities. The residents and their families are involved for all exits or discharges to and from the service. The clinical service manager and RNs interviewed were knowledgeable in the transfer/discharge process.
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 medicine management policies and procedures that align with recognised standards and guidelines for safe medicine management practice. Registered nurses administer medications with senior caregivers checking when required. Medication education and medication competencies have been completed annually. The service uses a four-weekly robotic roll system. All medication is checked on delivery against the electronic medication chart and any pharmacy errors recorded and fed back to the supplying pharmacy. All medications are stored safely. The medication fridge is maintained within the acceptable temperature range. All eye drops, and ointments were dated on opening. There were no residents self-medicating on the day of audit. Standing orders in place and have been reviewed October 2018, next due for review in 2019. Ten medication charts reviewed met legislative requirements. All residents have individual medication orders with photo identification and allergy status documented. Medications had been signed as administered in line with prescription charts. Appropriate practice was demonstrated on the witnessed medication round.
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	There is a food services policy and procedure manual. All food is cooked onsite. A dietitian has reviewed and approved the menu. All residents have a dietary requirements/food and fluid chart completed on admission. The cook maintains a folder of residents' dietary requirements that

		include likes/dislikes. There is a list on the wall which is updated weekly, so the kitchen staff are always up to date with resident changes. Alternatives are offered, and alternatives are provided as needed. Specialised utensils and lip plates are available as required. Residents and relatives interviewed, confirmed likes/dislikes are accommodated and alternatives offered. Perishable foods in the chiller and refrigerators are date-labelled and stored correctly. Fridge and freezer temperatures are checked consistently twice a day and periodically at midnight. The kitchen environment temperature is consistently recorded between 25-30 degrees as the air cooler is not working. This had been identified at the previous audit. The service was awaiting approval from head office, this was confirmed on the day of the audit. There is a verified food control plan. The kitchen is clean and has a good workflow. Chemicals are stored safely, and safety datasheets are available. Personal protective equipment is readily available, and staff were observed to be wearing hats, aprons and gloves. Residents and family interviewed were very complimentary about the food service.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	The service records the reasons for declining service entry to potential residents should this occur and communicates this to potential residents/family/whānau. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred to the referring agency if entry were declined.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Initial assessments and risk assessments are completed on admission. InterRAI assessments were completed within expected timeframes for all resident files reviewed. The interRAI assessment and risk assessments are reflected in the long-term care plan. Additional assessments for falls, pressure injury prevention, nutrition, oral, pain, continence, behaviour, wound care and mood scale were utilised as required.

Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Care plans reviewed for long-term residents describe the individual support and interventions required to meet the resident goals. Initial care plans are developed on admission. The long-term care plans reflect the outcomes of risk assessment tools and the interRAI assessment. Care plans demonstrate service integration and include input from allied health practitioners. Short-term care plans were in use for changes in health status. These are evaluated regularly and either resolved, or if an ongoing problem, added to the long-term care plan. Residents/relatives interviewed confirmed they participate in the care planning process. Family members interviewed confirmed care delivery and support by staff is consistent with their expectations. There was evidence of service integration with documented input from a range of specialist care professionals. The two SMI under 65 files reviewed, showed individualised activities, access to the community and resident specific preferences.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Low	When a resident's condition alters, the RN initiates a review and if required GP review. There is evidence that family members were notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. Family notifications were included in the family contact form in the residents' files reviewed. The RNs discuss referrals to specialists such as speech and language therapists, wound care specialists, and the Nurse Maude service. The GP initiates medical referrals. Wound management policies and procedures are in place. A wound assessment plan and evaluations were in place for four superficial wounds. There were no pressure injuries on the day of audit. Wound care evaluations consistently document the progression and/or deterioration of the wounds. Adequate dressing supplies were sighted, and continence products are available. The residents' files included a urinary continence assessment, bowel management plan, and continence products used. Monitoring occurs for blood pressure, weight, vital signs, food and fluids, blood glucose, pain and challenging

		behaviours. The resident with an enabler, did not have a monitoring form consistently completed.
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 service employs an experienced activities coordinator, who works 30 hours per week. A monthly programme is developed in consultation with residents and reflects their interests and abilities. The programme is varied and provides group and individual activities to meet the hospital, and SMI residents' recreational preferences and interests. One-on-one contact is made with residents daily, who are unable to or choose not to participate in group activities. Residents have a social profile and interests and hobbies form completed over the first few weeks after admission, which forms the basis of an activities plan which is then reviewed six monthly. A record is kept of individual resident's activities and monthly progress notes are documented. The resident and families are involved in the development of the activity plan. Activities include (but are not limited to); daily exercises, newspaper reading, hand massages, quizzes, board games, baking, music, and crafts. Community visitors include church visitors and entertainers, kapa haka group and kindergarten groups. There are monthly outings and drives into the community with the shared van, and two monthly outings for more disabled residents using the wheelchair mobility care van. Outings include going out for afternoon tea or going to the beach. Resident and relative meetings are held two monthly and provides an opportunity for residents and relatives to feedback on the service and the activities programme. Maidstone currently has two residents under the age of 65. One of these residents prefers more one-on-one activities, and the other resident is supported to go out with support workers to catch up with friends, and to go shopping. Within the home this resident is offered to participate in watering the garden and plants, to provide a sense of purpose.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Long-term care plans reviewed had been evaluated by RNs six monthly, or when changes to care occurred and a new care plan generated. Residents are reassessed using the interRAI and applicable facility assessment tools. There are three-monthly clinical reviews by the

		medical practitioner or sooner if needs change. Medication charts are reviewed three monthly or more frequently as required. Short-term care plan evaluations are completed at weekly intervals or more often if required. Evaluations are conducted by the RNs with input from the resident, family, activities coordinator, caregivers and GP. Family are notified of any changes in the resident's condition, as evidenced in sampled resident files and confirmed in family interviews. Residents and family interviewed, confirmed their participation in care plan evaluations and this is evidenced in the files reviewed. Progress notes are documented each shift and evidence regular RN reviews related to care plan goals.
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	Referral to other health and disability services is evident in the residents' files sampled. The service facilitates access to other medical and non-medical services. There is documented evidence of referrals to the podiatrist, physiotherapist, and speech and language therapist. There are documented policies and procedures in relation to exit, transfer or transition of residents. The residents and the families are kept informed of the referrals made by the service.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Safety datasheets were readily accessible for staff. Chemicals were stored safely throughout the facility. Personal protective clothing was available for staff and seen to be worn by staff when carrying out their duties on the day of audit. Relevant staff have completed chemical safety training. Staff interviewed indicated a clear understanding of processes and protocols.
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 building holds a current warrant of fitness, which expires on 1 June 2019. Fire equipment is checked by an external provider. The maintenance person undertakes preventative and reactive maintenance. Daily maintenance requests are addressed. There is a scheduled

		maintenance plan in place. The electrical equipment has been tested and tagged. Clinical equipment has been calibrated and/or serviced. Essential contractors are available 24-hours. Hazard registers are in place for all areas. Hot water temperatures have been monitored monthly. The water temperatures for August, September and October have been consistently high, the maintenance person interviewed minutes of meetings confirmed the plumber is working on the tempering valve. Temperatures were checked on the day of the audit and were within the recommended range. The facility has sufficiently wide corridors with handrails for residents to safely mobilise using mobility aids. There is safe access to the outdoor areas. Seating and shade are provided. Residents were observed moving freely around the areas with mobility aids where required. The facility currently shares a bus with another facility, which is available for transportation of residents. The activities coordinator holds a current first aid certificate and is available for all bus trips. The prospective owner advised there are no plans at this stage to make changes to the environment, except continuing with ongoing maintenance and laundry upgrade (link to 1.4.6.3).
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 personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	All resident rooms have hand-washing facilities. There are sufficient communal toilets and showers to meet resident requirements. All communal toilets and bathrooms have appropriate signage and locks on the doors. Fixtures, fittings and flooring is appropriate. Communal, visitor and staff toilets are clearly identifiable, equipped with locks, flowing soap and paper towels.
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 resident rooms are spacious enough to allow residents to move about with mobility aids and wheelchairs, and allows for the use of hoists. Residents and families are encouraged to personalise their rooms as viewed on the day of audit. Residents were observed safely moving around the facility.

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	Maidstone has two lounges with several small seating areas placed around the facility. Residents and assistants can move freely. Activities occur in the main lounge, and residents interviewed stated they were able to use alternative communal areas if they did not wish to participate in communal activities being held in one of these areas.
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.	PA Low	Maidstone has policies and procedures in place for laundry and cleaning services. Product information and safety datasheets are available for all chemicals in use. All chemicals are securely stored. Staff receive training at orientation and through the in-service programme. All chemicals were clearly labelled. Protective personal equipment is available in the sluice. The laundry is provided by another Heritage Lifecare facility. There are two separate areas for clean and dirty laundry. There are colour coded linen bags in use. Residents and relatives reported satisfaction with the current laundry services. There were no plans documented at the time of audit to manage laundry services when the service moves away from Heritage Lifecare. The prospective purchaser has plans to develop a laundry within the facility.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	There is an emergency/disaster management plan in place to ensure health, civil defence and other emergencies are included. The current fire evacuation plan was approved by the New Zealand Fire Service on the 9 January 2007. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service; the most recent being in August 2018. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures. There are adequate supplies in the event of a civil defence emergency, including sufficient food, water, blankets and alternate gas cooking facilities (BBQ and portable gas hob) available. The facility has emergency lighting and torches. All RNs employed have up-to-date first aid certificates. Smoke alarms, sprinkler system and exit signs are in place in the building. The call bell system is available in all resident areas, (ire, bedrooms, ensuite toilet/showers, communal toilets, dining

		rooms). Residents were observed to have their call bells in close proximity.
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	General living areas are heated via large heat pumps, and resident rooms are appropriately heated with individual heaters. All resident rooms have external windows and are well ventilated. The facility has plenty of natural light. All residents interviewed, stated they were happy with the temperature of the facility. There were no residents who smoke on the day of the audit. Residents and family interviewed, stated they were happy with temperature management.
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 be appropriate to the size and scope of the service.	FA	The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the quality management system. A RN is the designated infection control coordinator. The infection control team is included as part of the staff meetings. Internal audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The infection control programme has been reviewed annually. Visitors are asked not to visit if they have been unwell. There are hand sanitisers throughout the facility and adequate supplies of personal protective equipment.
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	Infection control is managed by the infection control coordinator (RN). The infection control coordinator has maintained current knowledge of infection prevention and control. The infection control coordinator has access to infection control personnel within the district health board, laboratory services and the GP.
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	FA	The infection control manual outlines a range of policies, standards and guidelines and includes the infection control programme, responsibilities and oversight, training and education of staff. The policies have been reviewed.

implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.		The prospective owner has policies and procedures for the management of infection control and these will transfer to the service (link to 1.2.1.1).
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred. Staff receive education on orientation and one-on-one training as required. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to visitors that is appropriate to their needs. Resident education occurs at resident meetings such as use of sanitisers and hand washing.
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 is an integral part of the infection control programme and is described in the infection control policy. Effective monitoring is the responsibility of the infection control coordinator. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. Surveillance data is available to all staff. Corrective actions are established where trends are identified. Monthly infection data is collected for all infections based on signs and symptoms of infection. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the clinical services manager. There have been no outbreaks since the previous audit.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility, and demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities.

		On the day of audit, no residents were using restraints and two residents were using wheelchair lap belts as enablers, which were the least restrictive and used voluntarily at their request. All documentation was current and completed. Risks have been identified and are listed in the care plan. The monitoring form to indicate when the enabler is in place and checked has not been consistently documented (link 1.3.6.1). The enabler is reviewed on a six-monthly basis. The prospective owner has policies and procedures in place to guide staff in the safe use of restraint and its minimisation as well as for use of enablers. The prospective provider is experienced in the requirements of the standard, as it pertains to aged residential care.

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 1.2.1.1 The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.	PA Low	The prospective owner explained that he will engage the assistance of a contractor to transition the service to the new management, culture, policies and procedures. The prospective owner discussed an education programme for staff to orient the staff to the new management. This plan is not yet documented.	There is no transition plan documented to assist the transition to the new ownership, such as implementation of the new policies and procedures.	Ensure that the transition to the new management and owner is planned and documented. 30 days
Criterion 1.2.3.7 A process to measure achievement against the quality and risk management plan is implemented.	PA Low	The service documents comprehensive monthly quality meetings. The meetings include reports from all service areas as well as action plans documented, following internal audits and quality data collection. The action plans were followed up and signed off. Not all audits were	(i)Not all audits have been completed as per schedule; examples include the continence audit, the daily care audit and the resident handling audit for August, and the uniform audit for October. (ii) Issues identified at the quality meeting were not always documented as followed up and	(i)Ensure that audits are undertaken as per schedule. (ii) Ensure that issues identified at meetings are followed up and signed off.

		documented as undertaken as per the schedule and maintenance issue identified were not always followed up from meeting to meeting.	completed at subsequent meetings, examples include; maintenance issues identified during the May, June and July meetings.	90 days
Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Low	Monitoring forms are completed for monthly weights and vital signs. There are other monitoring forms available as required for food and fluids, and challenging behaviours. However, monitoring forms for the enabler have not been consistently documented.	The monitoring chart for the enabler has not been consistently completed.	Ensure all monitoring charts are completed as per policy and care planning instruction. 90 days
Criterion 1.4.6.3 Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.	PA Low	Laundry services are provided by a close-by Heritage Lifecare service. There are processes and procedures in place to manage this. The prospective owner has plans to move the laundry back onsite. Plans are not yet documented to manage laundry services. Advised that the laundry will be reinstated as soon as possible. Laundry will continue to be outsourced (to George Manning Hospital laundry) for the first 2 months after sale.	There was no documented plan in place at the time of audit to manage laundry services once the service moved away from Heritage Lifecare.	Ensure that there are laundry services available to the service. 90 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.