# Lester Heights Hospital Limited - Lester Heights Hospital

## 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Lester Heights Hospital Limited

**Premises audited:** Lester Heights Hospital

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 22 September 2016 End date: 23 September 2016

**Proposed changes to current services (if any):**

**Total beds occupied across all premises included in the audit on the first day of the audit:** 32

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

## General overview of the audit

Lester Heights Hospital and Residential Care is certified to provide rest home and hospital levels of care for up to 35 residents. On the day of the audit there were 32 residents living at the facility. The experienced owner/manager is supported by a clinical manager, who is a registered nurse. Residents and family interviewed were complimentary of the service they receive.

A provisional audit was conducted to assess a prospective new owner for the facility and to assess the current 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. The prospective owners were interviewed on the second day of the audit.

This audit identified that an improvement is required around care planning. There is one area of continuous improvement awarded around meeting the needs of Māori.

## Consumer rights

Information about services provided is readily available to residents and families/whānau. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is available in the information presented to residents and their families during entry to the service. Policies are implemented to support rights such as privacy, dignity, abuse and neglect, culture, values and beliefs, complaints, advocacy and informed consent. Māori values and beliefs are respected. Care planning accommodates individual choices of residents and/or their family/whānau. Informed consent processes are adhered to. Residents are encouraged to maintain links with their community. Complaints processes are implemented and complaints and concerns are managed appropriately.

## Organisational management

Services are planned, coordinated, and are appropriate to the needs of the residents. An owner/manager is responsible for the day-to-day operations of the care facility. She is supported by a clinical manager/registered nurse. Quality and risk management processes are established. Quality goals are documented for the service. A risk management programme is in place, which includes a risk management plan, incident and accident reporting, and health and safety processes. Adverse, unplanned and untoward events are documented by staff. The health and safety programme meets current legislative requirements. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. A staff education and training programme is embedded into practice. Registered nursing cover is provided twenty-four hours a day, seven days a week. There are adequate numbers of staff on duty to ensure residents are safe. The residents’ files are appropriate to the service type.

## Continuum of service delivery

There is a comprehensive admission package on all services and levels of care provided. The registered nurses are responsible for each stage of service provision. A registered nurse assesses and develops the care plan documenting supports, needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed in resident records demonstrated service integration and were reviewed at least six monthly. Resident files included the general practitioner, specialist and allied health notes. Residents and families commented positively on the care received at Lester Heights.

Medication policies reflect legislative requirements and guidelines. Registered nurses are responsible for administration of medicines and complete annual education and medication competencies. The medicine charts reviewed meet prescribing requirements and were reviewed at least three monthly.

An activity coordinator oversees the activity programme for the rest home and hospital residents including the younger people. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical, cultural and cognitive abilities and preferences for each resident group.

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

## Safe and appropriate environment

There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Chemicals are stored safely throughout the facility. The building holds a current warrant of fitness. There is safe access to the communal areas and outdoor seating and shade. Resident bedrooms are personalised. All bedrooms have hand basins. There are adequate communal shower/toilet facilities. Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. Systems and supplies are in place for essential, emergency and security services. There is a staff member on duty at all times with a current first aid certificate.

## Restraint minimisation and safe practice

Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort. At the time of the audit, six residents (hospital level) were using restraints and no residents were using enablers. Staff receive regular education and training on restraint minimisation.

## Infection prevention and control

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is reviewed annually and meets the needs of the service. The infection control coordinator has attended external education. Relevant infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

## 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** | 1 | 48 | 0 | 0 | 1 | 0 | 0 |
| **Criteria** | 1 | 99 | 0 | 0 | 1 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **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 | The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) brochures are accessible to residents and their families. A policy relating to the Code is implemented and staff interviewed (one owner/manager, one clinical manager, two healthcare assistants, one registered nurse (RN), one cook, one activities coordinator, one maintenance, one cleaner and one laundry) could describe how the Code is incorporated into their everyday delivery of care. Staff receive training about the Code during their induction to the service, which continues annually through the staff education and training programme. |
| 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 | There are established informed consent policies/procedures and advanced directives. General consents including photographs were obtained on admission and sighted in six of six resident files reviewed (four hospital residents including one on a medical contract, one with a long-term chronic health condition and one young person with a disability, and two rest home level residents). Advance directives for continuing care (where appropriate) were completed and on the residents’ files. Resuscitation plans were sighted in all files. Where the resident was deemed incompetent by the general practitioner there was documented evidence of discussions held with the enduring power of attorney for medically indicated not for resuscitation status.  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 healthcare assistants (HCAs) and registered nurses interviewed demonstrated a good understanding in relation to informed consent and informed consent processes.  Family and residents interviewed confirmed they have been made aware of and fully understand informed consent processes and that appropriate information had been provided.  Six admission agreements reviewed had been signed. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Health and Disability advocacy brochures are included in the information provided to new residents and their family/whānau during their entry to the service. Residents and family interviewed were aware of the role of advocacy services and their right to access support. The complaints process is linked to advocacy services.  Staff receive regular education and training on the role of advocacy services, which begins during their induction to the service. |
| 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 | The service has an open visiting policy. Residents may have visitors of their choice at any time. The service encourages their residents to maintain their relationships with friends and community groups. Assistance is provided by the care staff to ensure that the residents participate in as much as they can safely and desire to do, evidenced through interviews and observations. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints procedure is provided to residents and families during entry to the service. Access to complaints forms are located at reception. Complaints forms include contact details for the Health and Disability Advocacy Service.  The owner/manager maintains a record of all complaints received, using a complaints register. Three complaints have been received in 2016 (year-to-date). Documentation, including follow up letters and resolution demonstrates that complaints are well-managed. One recent complaint received by a resident on 5 September 2016 is currently under investigation by the DHB. The DHB portfolio manager has been kept informed by the owner/manager.  Discussions with residents and families/whānau confirmed they were provided with information on the complaints process and remarked that any concerns or issues they had were addressed promptly. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Details relating to the Code and the Health and Disability Advocacy Service are included in the resident information that is provided to new residents and their families. The staff discuss aspects of the Code with residents and their family on admission. Discussions relating to the Code are also held during the resident/family meetings. All seven residents (four rest home level and three hospital level) and three family (one rest home level and two hospital level) interviewed reported that the residents’ rights were being upheld by the service.  The prospective buyers manage an aged care facility in Auckland and have a good understanding of consumer rights. |
| 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 | The residents’ personal belongings are used to decorate their rooms. Privacy signage is on communal toilet and shower doors. All residents’ rooms are single use.  The two healthcare assistants interviewed reported that they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas. They reported that they promote the residents' independence by encouraging them to be as active as possible. Residents and families interviewed and observations during the audit confirmed that the residents’ privacy is respected.  Guidelines on abuse and neglect are documented in policy. Staff receive annual education and training on abuse and neglect, which begins during their induction to the service. |
| 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. | CI | The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service and has exceeded the required standard in this area. The care staff interviewed reported that they value and encourage active participation and input from the family/whānau in the day-to-day care of the residents. There were ten residents living at the facility who identified as Māori.  Specific Māori cultural needs are identified on the cultural assessment, completed by the facility’s Māori advocate, and are linked to the Māori residents’ care plans (evidenced in two of two Māori residents’ files reviewed). Two residents and three family, all who identified as Māori, reported that their cultural needs were being met by the service.  Māori consultation is sought internally and externally by the service. Several care staff identify as Māori. Staff education on cultural awareness begins during their induction to the service and continues annually. The healthcare assistants interviewed provided examples of how they ensure Māori values and beliefs are upheld by the service. |
| 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 | The service identifies the residents’ personal needs and desires from the time of admission. This is achieved in collaboration with the resident, whānau/family and/or their representative. The staff demonstrated through interviews and observations that they are committed to ensuring each resident remains a person, even in a state of decline. Beliefs and values are discussed and incorporated into the residents’ care plans, evidenced in all six care plans reviewed (two rest home level, and four hospital level). Residents and family/whānau interviewed confirmed they were involved in developing the resident’s plan of care, which included the identification of individual values and beliefs. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Professional boundaries are discussed with each new employee during their induction to the service. Professional boundaries are also described in job descriptions. Interviews with the care staff confirmed their understanding of professional boundaries including the boundaries of the healthcare assistants’ role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings, and performance management if there is infringement with the person concerned. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | Good practice was evident. A registered nurse is available 24 hours a day, seven days a week. A general practitioner (GP) visits the facility once a week. Residents are reviewed by a general practitioner (GP) every three months at a minimum.  Resident/family meetings are held monthly, led by the activities staff. Residents and family/whānau interviewed reported that they are either satisfied or very satisfied with the services received. A resident/family satisfaction survey is completed annually and confirmed high levels of satisfaction with the services received.  The service receives support from the district health board (DHB) which includes (but is not limited to) specialist visits. Physiotherapy services are available as needed. A van is available for regular outings.  The GP interviewed is satisfied with the care that is being provided by the service. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | The open disclosure policy is based on the principle that residents and their families have a right to know what has happened to them and to be fully informed at all times. The policy also describes that open disclosure is part of everyday practice. The care staff interviewed understood about open disclosure and providing appropriate information and resource material when required.  Families interviewed confirmed they are kept informed of the resident`s status, including any events adversely affecting the resident. Fifteen accident/incident forms reviewed reflected documented evidence of families being informed following an adverse event unless the (cognitively aware) resident chooses to notify family themselves. This information was documented on the accident/incident forms. Progress notes also identify family/whānau being kept informed.  An interpreter service is available and accessible if required through the local district health board. Families and staff are utilised in the first instance. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | All 35 beds at Lester Heights are certified for dual-purpose - either for rest home or hospital levels of care. On the day of the audit, there were a total of 32 residents living at the facility. Eight residents were receiving rest home level care. This included three on respite care. Twenty-four residents were receiving hospital level care including four on the on the young persons with disability contract (hospital level), and two residents on the long-term chronic conditions.  The facility has a 2016 strategic plan, which identifies the purpose, values, scope, direction, goals and specific aims for the calendar year. Services are planned to ensure residents’ needs are being met.  The owner/manager has maintained over eight hours annually of professional development activities related to managing an aged care facility.  New owner details  The prospective provider (a husband/wife) own and operate a 21-bed rest home in Auckland. The prospective provider reported that they received no areas for improvement (partial attainments) at their last surveillance audit and have a clear understanding of the Health and Disability Sector Standard (HDSS). A transition plan for the purchase has been developed. The prospective provider acknowledges that they do not have experience managing a hospital level facility. Plans are in place to promote the existing clinical manager to facility manager/clinical manager. This individual has held a facility management role in the past and has worked in aged care for 20 years. It is understood that she will be required, as the facility manager, to regularly attend professional development activities relating to managing an aged care facility. A registered nurse has been employed 30 hours per week to cover clinical responsibilities previously undertaken by the clinical manager. She begins employment on 1 November 2016. One of the owners is planning to spend three to four days per week on site and will also do the maintenance  A quality advisor provides regular on-site consultation and will remain in her role. Current policies and procedures, developed by the quality advisor, will remain unchanged. Environmental changes described in the transition plan include installing CCTV cameras and upgrading the flooring in the facility. The current owner/manager has agreed to provide phone support on an as needed basis. |
| 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 clinical manager oversees operations in the absence of the owner/manager. The prospective provider plans to oversee operations in the absence of the facility manager/clinical manager with a registered nurse (RN) appointed to oversee clinical operations. |
| 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 | A quality and risk management system is being maintained, which is understood and being implemented as confirmed during interviews with the owner/manager and clinical manager. Policies and procedures are maintained by the external quality advisor who ensures they align with current good practice and meet legislative requirements. Policies have been updated to reflect processes around InterRAI and pressure injuries.  Quality management systems are linked to internal audits, incident and accident reporting, health and safety reporting, infection control data collection and complaints management. Data that is collected is analysed and compared monthly and annually for a range of adverse event data (eg, skin tears, bruising, falls, pressure injuries). Corrective actions are documented and implemented where improvements are identified. For example, a corrective action plan was implemented on 20 March 2016 around prevention of pressure injuries, wound management and assessments. Corrective actions are regularly evaluated. Information is shared with all staff as confirmed in meeting minutes and during interviews.  Staff, residents and family/whānau interviews confirmed any concerns they have were addressed by management and examples of quality initiatives were provided.  A 2016 risk management plan is in place. Staff receive health and safety training, which is initiated during their induction to the service. A health and safety committee has been established. The committee meets quarterly. All staff are involved in health and safety, which is a regular topic in staff meetings. Actual and potential risks are documented on the hazard register, which identifies risk ratings and documents actions to eliminate or minimise the risk. A recent staff in-service was undertaken to address updates to health and safety legislation.  Falls management strategies include sensor mats, and the development of specific falls management plans to meet the needs of each resident who is at risk of falling. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | There is an incident reporting policy that includes definitions and outlines responsibilities. Individual reports are completed for each incident/accident with immediate action noted including any follow up action(s) required. Incident/accident data is linked to the organisation's quality and risk management programme. Fifteen accident/incident forms were reviewed. Each event involving a resident reflected a clinical assessment and follow up by a registered nurse. Neurologic observations were conducted for suspected head injuries. An accident/incident form is completed for pressure injuries.  The owner/manager and clinical nurse manager reported that they are aware of their responsibility to notify relevant authorities in relation to essential notifications. A section 31 report was sighted for one (stage three) pressure injury. |
| 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 policies are in place, including recruitment, selection, orientation and staff training and development. Six staff files reviewed (one clinical manager, one RN, one cook, three healthcare assistants) included evidence of the recruitment process, signed employment contracts, police vetting, and completed orientation programmes. The orientation programme provides new staff with relevant information for safe work practice. Competencies are completed specific to worker type. Staff interviewed stated that they believed new staff were adequately orientated to the service.  A register of current practising certificates for all health professionals is maintained.  There is an annual education schedule that is being implemented. In addition, opportunistic education is provided. Two of five RNs have completed their InterRAI training. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is an organisational staffing policy that aligns with contractual requirements and includes skill mixes. The clinical manager is an experienced RN who works full time Monday - Friday. A minimum of one staff RN is on site 24 hours a day, seven days a week. Staffing is flexible to meet the acuity and needs of the residents. A casual pool of staff are available as needed. Interviews with residents and families confirmed staffing overall was satisfactory.  The prospective provider has had time to complete a thorough investigation into current staffing needs. Plans are in place to promote the clinical manager/RN to facility manager/clinical manager and an additional staff RN has been employed 30 hours per week (effective 1 November 2016). The only change identified in staffing is that the maintenance will be done by the prospective provider (husband), who plans to be on site four days a week. Plans are in place to keep the mix and quality of staff the same as that currently in place. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The residents’ files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into each resident’s individual record. An initial support plan is also developed in this time. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents’ files are protected from unauthorised access by being held in secure rooms. Archived records are secure in a separate locked area.  Residents’ files demonstrate service integration. Entries are legible, dated, timed and signed by the relevant healthcare assistant or nurse, including designation. |
| 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’ entry into the service is facilitated in a competent, equitable, timely and respectful manner. Pre-admission information packs include information on the services provided for resident and families. Admission agreements for long-term residents aligned with all contractual requirements. Exclusions from the service are included in the admission agreement. |
| 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 were 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 transfer system used ensures all relevant documentation is made available to the receiving provider. The residents and their families are involved for all exit or discharges to and from the service. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | There are policies and procedures in place for safe medicine management that meet legislative requirements. Registered nurses who administer medications have been assessed for competency on an annual basis. Registered nurses complete syringe driver training. Education around safe medication administration has been provided. Medications received (robotic rolls), are checked on delivery by the RN. Standing orders were current and met the legislative requirements around standing orders. All medications are stored safely. All eye drops are dated on opening. The medication fridge is monitored daily.  All 12 medication charts reviewed (eight hospital and four rest home) met legislative prescribing requirements. The GP has reviewed the medication charts three monthly. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | All meals at Lester Heights are prepared and cooked on site by a qualified cook. All staff have attended food safety and hygiene training. There is a four weekly seasonal menu, which had been reviewed by a dietitian in May 2016. The service accommodates cultural food preferences for Māori with a Māori menu (link to CI 1.1.4.3). The cook receives a dietary profile of resident dietary requirements and any likes or dislikes. Special diets including modified foods are provided.  Staff were observed assisting residents with their meals and drinks in the main dining room. A smaller dining room/lounge is used to maintain the dignity of residents requiring additional assistance or feeding of meals.  Fridge, freezer and end-cooked temperatures are monitored daily. A kitchen cleaning schedule is in place and implemented. Chemicals are stored safely within the kitchen.  Resident meetings and surveys, along with direct input from residents, provide resident feedback on the meals and food services. Residents and family members interviewed were very satisfied with the food and confirmed alternative food choices were offered for dislikes. |
| 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 | There is an admission information policy. The reasons for declining entry would be if the service were unable to provide the care required or there are no beds available. Management communicate directly with the referring agencies and family/whānau as appropriate if entry was declined. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | The RN completes an initial assessment on admission including risk assessment tools. An InterRAI assessment is undertaken within 21 days of admission and six monthly, or earlier due to health changes. Resident needs and supports are identified through the ongoing assessment process in consultation with significant others. InterRAI assessments, assessment notes and summaries were in place for all residents’ files sampled that had been at the service for longer than 21 days. Not all long-term care plans in place reflected the outcome of the assessments (link 1.3.5.2). |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Moderate | Resident files reviewed were resident focused and individualised. Identified support needs as assessed were included in the care plans for two of six resident’s files. Care plans evidenced resident (as appropriate) and family/whānau involvement in the care plan process. Relatives interviewed confirmed they were involved in the care planning process.  Resident files demonstrate service integration and evidence of allied health care professionals involved in the care of the resident such as the physiotherapist and dietitian. Short-term care plans were in place for short-term needs. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | When a resident's condition alters, the registered nurse initiates a review and if required a GP or nurse specialist consultation. 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. Discussions with families were documented in the resident’s progress notes.  Adequate dressing supplies were sighted in the treatment room. Wound management policies and procedures are in place. Initial wound assessments and ongoing evaluations were in place for three residents with skin tears and two residents with pressure injuries (one community acquired). There was a range of equipment readily available to minimise pressure injury. There is access to a wound nurse specialist at the DHB as required.  Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified.  Short-term care plans document appropriate interventions to manage short-term changes in health such as infections.  Monitoring forms are used, for example, observations, weight, food and fluid, behaviour, blood sugar levels and neurological signs. |
| 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 activity coordinator (also the Māori Liaison officer) is employed for 35 hours per week Monday to Friday to coordinate and implement and activity programme. She is supported by an activity assistant (also the maintenance person) who takes exercises (has received physiotherapy instruction), activities and outings. Both activity staff have current first aid certificates. There is an integrated rest home and hospital activity plan that meets the group and individual preferences of each resident group. Activities take place in the main lounge and in the smaller lounge for quieter one-on-one activities for more dependant residents. The programme is varied and interesting with board games, quizzes, reading, bowls, exercises, scrapbooking and pampering, specific activities have been developed for Māori (link CI 1.1.4.3). Links with the community involve speakers, visiting children, Kapa Haka group, music entertainers and church services. There are outings into the community and inter-home visits.  A social history and activity plan is completed on admission in consultation with the resident/family (as appropriate) and reviewed six monthly. Residents and families have the opportunity to feedback on the activity programme through meetings and surveys. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | All initial care plans reviewed were evaluated by the RN within three weeks of admission. In all except one file sampled, the long-term lifestyle plans have been reviewed at least six monthly or earlier for any health changes. One resident was new to the service. The written evaluation documents the resident’s progress against identified goals. The GP reviews the residents at least three monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the progress notes. |
| 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 was evident in the resident files sampled. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files.  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 and product sheets are readily accessible for staff. Chemical bottles sighted have correct manufacturer labels. Chemicals are stored in a locked chemical cupboard. There are chemical spills kits located throughout the facility which are easily accessible. Personal protective clothing is available for staff and seen to be worn by staff when carrying out their duties on the day of audit. |
| 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 has a current building warrant of fitness that expires 1 December 2016.  The full-time maintenance person ensures daily maintenance requests are addressed and a planned maintenance schedule is maintained. There is an ongoing refurbishment/refresher of bedrooms as they become vacant. A carpet replacement plan has commenced and there has been some landscaping of gardens. Monthly inspections include call bell testing, monthly fire checks and hot water temperature monitoring. Temperature recordings reviewed were between 43-45 degrees Celsius. Essential contractors are available 24 hours. The maintenance person is a trained electrical tester and completes checks on all facility and resident electrical equipment.  Annual calibration and functional checks of medical equipment is completed by an external contractor.  The facility has wide corridors with sufficient space for residents to safely mobilise using mobility aids.  There is safe access the outdoor areas. Seating and shade is provided. There is a designated outdoor smoking area.  The RNs and HCAs interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans including hoists and pressure injury prevention equipment. |
| 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 basins. There are adequate numbers of communal toilet and shower facilities for each wing. The toilets and showers are of an appropriate design to meet the needs of the residents. Communal toilet facilities have a system that indicates if it is engaged or vacant. There are privacy curtains in place. |
| 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 | There are 29 single rooms and 3 double rooms. All rooms were single occupancy at the time of the audit. The double rooms are only shared when a married couple requests this. There is adequate room to safely manoeuvre mobility aids and transferring equipment such as hoists in the resident bedrooms. Residents and families are encouraged to personalise their rooms. Bedrooms viewed were personalised. |
| 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 within the facility include a large open plan main lounge and dining room and a smaller lounge/dining room for small group and one-on-one activities. There is a seating area at the front entrance. Seating and space in the main lounge is arranged to allow both individual and group activities to occur. The communal areas are easily accessible for residents or with staff assistance. |
| 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 | There are adequate policies and procedures for the safe and efficient use of laundry services. There are dedicated laundry and cleaning staff seven days a week. The laundry is located downstairs with keypad access. All linen and personal clothing is laundered on-site. Dirty linen is delivered to the (downstairs) laundry by a chute. The laundry is well equipped and well ventilated. Internal and external audits (by the chemical provider) monitor the effectiveness of the cleaning and laundry processes. The cleaner’s trolley is kept in designated locked areas when not in use. There are two sluice rooms with personal protective equipment readily available. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | Emergency and disaster policies and procedures, and a civil defence plan are documented for the service. Fire drills occur every six months (at a minimum). The orientation programme and annual education and training programme include fire and security training. Staff interviewed confirmed their understanding of emergency procedures. Required fire equipment was sighted on the day of audit. Fire equipment has been checked within required timeframes.  A civil defence plan is documented for the service. There are adequate supplies available in the event of a civil defence emergency including food, water, and blankets. A gas barbeque is available.  A call bell system is in place. Residents were observed in their rooms with their call bell alarms in close proximity. Call bells are checked monthly by maintenance staff.  There is a minimum of one staff member available 24 hours a day, seven days a week with a current first aid/CPR certificate. Both activities staff also hold current first aid/CPR certificates. |
| 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 | Residents are provided with adequate natural light and safe ventilation. The environment is maintained at a comfortable temperature within bedrooms and communal areas. There are sufficient doors and opening windows for ventilation. All bedrooms have windows, which allow for plenty of natural light. |
| 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 | A registered nurse is the infection control coordinator and has a job description that outlines the responsibility of the role. The infection control coordinator provides monthly reports to management. The infection control programme has been reviewed annually.  Visitors are asked not to visit if they are unwell. Hand sanitisers were appropriately placed throughout the facility. Residents and staff are offered the annual influenza vaccine. |
| 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 infection control coordinator has completed the (on-line) Ministry of Health infection control education and attended an infection control study day at the DHB (September 2016). There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The infection control coordinator has access to the infection control nurse specialist at the DHB, laboratory technician, GPs and public health. |
| 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 are practical, safe, and appropriate/suitable for the type of service provided. | FA | There are infection control policies and procedures appropriate for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies have been developed and reviewed (June 2014) by an infection control consultant and the content of policies reflected current good practice. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Infection prevention and control education is included in the staff orientation and is a regular staff in-service topic. The DHB infection control nurse provides advice and education. Staff meetings also provide a forum for education delivered by the infection control coordinator and clinical manager. Resident education occurs as part of daily cares as appropriate. |
| 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 | There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Individual infection reports and short-term care plans are completed for all infections. A monthly surveillance report includes number of infections by type, trends identified and any corrective actions required. Infection control data and relevant information is displayed for staff. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is discussed at staff meetings. Internal audits for infection control are included in the annual audit schedule. There is close liaison with the GP that advises and reviews the use of antibiotics. Systems in place are appropriate to the size and complexity of the facility  There have been no outbreaks. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There are policies around restraints and enablers. Six residents (hospital level) were using restraints and no residents were using enablers.  Staff receive mandatory training around restraint minimisation. In addition to in-service training, staff are requested to complete a restraint competency questionnaire. All care staff interviewed were able to describe the difference between an enabler and a restraint. |
| Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | FA | A restraint approval process and a job description for the restraint coordinator are in place. Restraint minimisation policies and procedures describe approved restraints. A registered nurse is the designated resident coordinator. A restraint committee, which includes the clinical manager, RN, senior healthcare assistant and GP, meets three-monthly. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | The restraint coordinator is responsible for assessing a resident’s need for restraint. Restraint assessments are based on information in the resident’s care plan, discussions with the resident and family, and observations by staff. Assessment tools are in place for restraints and enablers.  Three hospital level residents’ files where restraint was being used, were selected for review. Each file included a restraint pre-assessment and a restraint risk assessment. Both assessments are completed before restraint is initiated. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | A restraint register is in place. The register identifies the residents that are using a restraint, and the type of restraint used. Six residents were listed on the register. Types of restraints used included bed rails and lap belts. The restraint assessments reviewed identified that restraint is being used only as a last resort. The restraint assessment process includes determining the frequency of monitoring residents while on restraint. Monitoring forms are completed when the restraint is put on and when it is taken off, evidenced in all three residents’ files where restraint was being used. Two of three residents’ files reflected the use of restraint in the residents’ care plans (link 1.3.5.2). |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | Restraint use is formally reviewed on an evaluation form six-monthly (at a minimum) by the restraint coordinator, and meets requirements of the standard. When restraint is initiated, reviews take place with greater frequency. The restraint committee meets three-monthly to discuss residents on restraint. Restraint use is a regular agenda item in the monthly RN meetings and staff meetings. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | The restraint programme, including reviewing policies and procedures and staff education is regularly evaluated, evidenced in the document control for restraint policies and procedures and in the three-monthly restraint committee meeting minutes. |

# Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.3.5.2  Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Moderate | Two long-term care plans described the required supports/needs as identified through the assessment process. | Four long-term care plans reviewed identified shortfalls around documented interventions to meet the resident’s current needs/supports as follows; 1) one resident under the medical services did not have any documented interventions for a) high risk of pressure injury, b) challenging behaviours as per the GP notes and c) oedematous and leaking limbs. 2) There were no documented interventions, de-escalation techniques or alternative strategies for one rest home resident with identified challenging behaviours. 3) The care plan did not identify a (long-term chronic health condition) resident’s previous weight loss, dietitian involvement and interventions for management of weight loss. 4) Restraint use for one hospital resident was not identified in the long-term care plan. 5) There was no diabetic management plan in place for three insulin dependent residents (one rest home, one long-term chronic health condition and one younger person). | Ensure care plans reflect the resident’s current health status, needs and supports.  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.

|  |  |  |  |
| --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 1.1.4.3  The organisation plans to ensure Māori receive services commensurate with their needs. | CI | A number of quality initiatives have been implemented to ensure Māori receive culturally appropriate services. | A number of quality initiatives have been implemented to meet the needs of the Māori residents. Three years ago there were no residents living at the facility who identified as Māori. During the audit, 10 out of 32 residents identified as Māori, an increase of 31%. Barriers to access for Māori have been addressed by the following examples provided during the audit. A designated kaumātua, the clinical manager and the activities coordinator all identify as Māori and hold specific responsibilities relating to meeting the needs of Māori. They have completed their level 4 National Certificate in Hauora – Māori Health and are identified in the resident information brochure as the facility’s Māori liaison officer, clinical manager and kaumātua. A Māori wing has been identified, named and blessed. Signage in Te Reo is placed throughout the facility and outside at the entrance to the facility. A specific menu has been developed for Māori with generally high levels of food satisfaction reported in interviews and in the satisfaction survey results. The activities programme includes activities and outings for Māori including genealogy and looking for connections with others; gathering pipis; and blessing food. A specific Māori assessment form is completed by the Māori liaison officer for each resident who identifies as Māori. Staff are available who are fluent in Te Reo. Protocols for Māori are being implemented around death and dying and include karakia with family and accommodating whānau to stay for extended periods of time. Interviews with two residents who identify as Māori and three families who identify as Māori confirmed their high levels of satisfaction with the services received. It was acknowledged by family that Māori do not like to place their whānau in homes but that Lester Heights was an exception and was considered ‘home’. |

End of the report.