

Leighton House Limited

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	Leighton House Limited
Premises audited:	Leighton House
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 18 January 2016 End date: 19 January 2016
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:	47

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Dementia Care New Zealand is the parent company of Leighton House. The service cares for up to 50 residents requiring hospital (geriatric and medical) and rest home level care. On the day of the audit there were 47 residents. The manager is well qualified and experienced for the role. Relatives and residents interviewed spoke positively about the service provided.

The surveillance audit was conducted against the relevant Health and Disability standards and the contract with the District Health Board. The audit process included a review of policies and procedures; the review of resident's and staff files, observations and interviews with relatives, staff and management.

Two of the three previous audit findings have been addressed around incident and accidents, and care planning. Further improvements are required in relation to registered nurse follow up of issues identified in progress notes. This audit an improvement required around aspects of medication management.

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.
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The service ensures there are regular meetings for residents and families. Complaints and concerns have been managed and a complaints register is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Leighton House has a quality and risk management system in place. Key components of the quality management system link to relevant facility meetings. The service is active in analysing data with evidence of benchmarking outcomes with other similar aged care facilities. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and appropriately managed. There is a comprehensive orientation programme that provides new staff with relevant and specific information for safe work practice. The staffing levels provide sufficient and appropriate caregiver coverage for the effective delivery of care and support. Staffing is based on the occupancy and acuity of the residents.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The registered nurses are responsible for care plan development with input from family. Relatives interviewed confirmed that the care plans are consistent with meeting residents' needs. Planned activities are appropriate to the resident's assessed needs and abilities and families advised satisfaction with the activities programme. Medications are prescribed and administered. 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

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building holds a current warrant of fitness.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Leighton House has a philosophy to actively minimise the use of restraint. There is a restraint policy that includes comprehensive restraint procedures and aligns with the standards. There is one resident assessed for the use of restraint and no residents using enablers.

Infection prevention and control

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

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	15	0	0	2	0	0
Criteria	0	36	0	1	3	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
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>A complaints policy and procedures have been implemented and residents and their family/whanau have been provided with information on admission. Complaint forms are available at the service. Staff interviewed were aware of the complaints process and to whom they should direct complaints.</p> <p>There is an up to date complaints folder in place and all five complaints reviewed including one verbal complaint, all document follow up in a timely manner. One complaint documented that the Health and Disability Commissioner Service had been involved and this complaint has been resolved to the service's satisfaction with no further findings. Family members interviewed advised that they are aware of the complaints procedure and how to access forms.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Two family members interviewed agreed that they are kept informed regarding all aspects of their relative's care (one rest home and one hospital). Five care plans reviewed (three hospital and two rest home) all had either a family member or resident signature on the care plans and multidisciplinary team meetings. Resident meetings are documented as taking place monthly</p> <p>Seven falls related incident forms reviewed all documented that family had been</p>

		informed.
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Leighton House is owned and operated by Dementia Care New Zealand. The service provides care for up to 50 residents requiring hospital, (medical and geriatric) and rest home level care. On the day of the audit there were 47 residents - ten at hospital level care and 37 at rest home level care. There were no residents under the medical component and no respite residents. All residents were under the aged care contract.</p> <p>The operations manager is supported by a clinical manager, who is a registered nurse. They are both experienced in their roles. There is a documented business plan that documents regular review and action plans to achieve performance indicators within set time frames.</p> <p>The operations and clinical managers have completed more than eight hours training related to managing a rest home and hospital in the past year.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>Dementia Care NZ has an organisation wide risk management plan in place. The quality and risk programme is very well implemented and has been monitored through the quality meeting and monthly reports to the head office management team. All quality data is logged and monitored by the operations manager and clinical manager onto a central data base and this is monitored both at head office and at Leighton House. Meeting minutes have been maintained for registered nurse meetings, quality meetings, staff meetings, infection control and health and safety meetings. Minutes sighted have included actions to achieve compliance where relevant and record that staff are well informed regarding quality data and any improvements needed. Discussions with staff confirmed their involvement in the quality programme. There is an implemented internal audit schedule and areas of non-compliance identified at audits have had corrective action plans developed and signed as completed. Benchmarking with other facilities occurs on data collected. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. The service has comprehensive policies/procedures to support service delivery including interRAI assessment and pressure injury prevention. All policies and procedures are reviewed regularly.</p> <p>Falls prevention strategies are implemented for individual residents. Relatives' are surveyed to gather feedback on the service provided and the outcomes are communicated to staff and families.</p>

<p>Standard 1.2.4: Adverse Event Reporting</p> <p>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.</p>	FA	<p>Incident and accident data has been collected, analysed and reported to meetings. Incident data is recorded onto a central database and benchmarked with other facilities. Discussions with the service confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Seven falls related incident forms were reviewed for December 2015. All reports and corresponding resident files reviewed evidence that appropriate clinical care has been provided following an incident. The incident reporting policy includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Neuro observations were documented for any falls involving a blow to the head and incidents were reflected in progress notes. This is an improvement on the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Six staff files were reviewed and included all appropriate documentation. Files reviewed included two registered nurses, one cook and three caregivers. Practicing certificates were viewed for registered nurses</p> <p>The service has a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Annual appraisals are conducted for all staff.</p> <p>There is a staff training programme in place that exceeds eight hours annually and attendance levels are high. The clinical manager and registered nurses are provided with ongoing training relevant to the roles within the wider group and through the DHB.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There is a staffing roster in place which provides sufficient staffing cover for the provision of care and service to residents. The clinical manager (a registered nurse) works full time Monday to Friday. In addition there is a registered nurse on duty each shift. Caregivers and family interviewed advised that sufficient staff are rostered on for each shift. There is a staff member on duty that has been trained in first aid at all times.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative</p>	PA Moderate	<p>The service uses individualised robotic sachets which are checked in on delivery by a registered nurse. A registered nurse was observed administering medications correctly. Medications and associated documentation were stored in a secure room with the exception of a resident's own medications. The</p>

<p>requirements and safe practice guidelines.</p>		<p>medication fridge is maintained in a safe temperature range. Ten of 10 medication charts were reviewed and all have three monthly medical reviews by the attending GP, however, not all resident medication documentation meets requirements. A Resident who self-medicates has not had all relevant checks and reviews completed. Resident photographs were on all 10 medication charts reviewed and all as required medications had a documented indication for use. An annual medication administration competency is completed for all staff administering medications and medication training had been conducted.</p> <p>Not all non-packed medications reviewed were dated when opened or were within expiry dates.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>All meals at the service are prepared and cooked on site by the cook. There is a rotating winter and summer menu which has been reviewed by a dietitian. Kitchen staff are trained in safe food handling and food safety procedures are adhered to. The service records all fridge and freezer temperatures daily. Staff were observed serving and assisting residents with their lunch time meals and drinks. Diets are modified as required. Resident dietary profiles and likes and dislikes are known to food services staff and any changes are communicated to the kitchen via the registered nurses. Supplements are provided to residents with identified weight loss issues. Resident meetings allow for the opportunity for resident feedback on the meals and food services generally. Family members interviewed indicated satisfaction with the food service.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Five resident care plans were reviewed for this audit. The care plans for all residents reviewed documented that care plan interventions were appropriate to the resident need and all documentation was in the correct section of the care plans. Short term care plans were in place as needed and evaluated. (Link to 1.3.3.3 for RN assessments) The service has addressed the previous audit finding.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>The care being provided is consistent with the needs of residents as demonstrated on the overview of the care plans, discussion with family, residents, staff and management. Short term care plans, turning charts, food and fluid records and behaviour monitoring charts were evident. In all files sampled the residents are receiving care that meets all their needs.</p> <p>Dressing supplies are available.</p> <p>Continence products are available and resident files include a urinary continence</p>

		<p>assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described.</p> <p>Continence management in-service and wound management in-service has been provided as part of annual training. Registered nurses interviewed were able to describe access to specialist services if required.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>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.</p>	FA	<p>There are four diversional therapists or training diversional therapists employed and between them they provided activities Monday to Sunday for all residents.</p> <p>There is generally one activity person in the AM and two in the PM enabling two different activities for differing resident needs.</p> <p>The programme is planned monthly and a copy is placed on the notice board. An activity plan is developed for each individual resident based on assessed needs. The activity plan is reviewed at least six monthly along with the residents nursing care plan. Residents are encouraged to join in activities that are appropriate and meaningful and are encouraged to participate in community activities. The service uses a van for resident outings.</p> <p>Residents were observed participating in activities in all units on the day of audit. Resident meetings provided a forum for feedback relating to activities. Family members interviewed discussed enjoyment of residents in the programme and the diversity offered to all residents.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Care plans reviewed were updated as changes were noted in care requirements. Care plan evaluations are comprehensive, related to each aspect of the care plan and recorded the degree of achievement of goals and interventions. Short term care plans are utilised and any changes to the long term care plan were dated and signed in files sampled. All care plans reviewed were evaluated within the required time frames.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>There is a current building warrant of fitness which expires on 1 March 2016.</p>
<p>Standard 3.5: Surveillance</p>	FA	<p>Infection surveillance and monitoring is an integral part of the infection control programme and is described in infection monitoring policy. A registered nurse is</p>

<p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>the designated infection control nurse. Monthly infection data is collected for all infections based on signs and symptoms of infection. All infections are individually logged monthly. The data has been monitored and evaluated monthly and annually and is benchmarked internally.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The service has a philosophy to actively minimise the use of restraint. There is a restraint policy that includes comprehensive restraint procedures and aligns with the standards. There is one resident with approval for arm restraint and no residents using enablers. Enablers are voluntary. Restraint usage is a discussion agenda at RN and quality meetings.</p>

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)
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	PA Moderate	<p>Policies and procedures are in place for the correct storage, managements and administration of medications .There is a room for the storage of medications.</p>	<p>One bottle of eye drops had not been dated when they were opened. One container of ensure was out of date and two bottles of Mylanta were not dated on opening and not stored in the fridge.</p>	<p>Ensure that all expired medications are returned to the pharmacy and that all eye drops and medications with a short life are dated when they are opened and stored correctly.</p> <p>60 days</p>
<p>Criterion 1.3.12.5</p> <p>The facilitation of safe self-administration of medicines by consumers where appropriate.</p>	PA Low	<p>There is one resident who self-administers Paracetamol. Discussion with the resident evidences that this resident is competent to self-administer medications</p>	<p>There is no lockable storage area in the resident's room for medications and review of the resident charts evidences that the assessment and consent to self-administer medications have not been reviewed.</p>	<p>Ensure all residents who self-administer medications have a secure medication storage system in their rooms and all residents who self-administer have an up to date assessment and</p>

				consent in place. 60 days
<p>Criterion 1.3.12.6</p> <p>Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.</p>	<p>PA Moderate</p>	<p>Medication charts for ten residents were reviewed. All medication charts had been signed by the GP and all document that a GP reviews medications at least three month. Staff administering medications have an up to date medication competency. Not all medication charts were completed correctly.</p>	<p>i)Three residents had more than one copy of their medication chart, four medication charts had no stop date for short term medications, one medication chart had one medication with no administration time documented and one medication had no start date documented; and ii) administration documentation evidenced that of the ten administration charts, one had signing gaps for inhaler medication and one had only one signature on the administration sheet for medication that requires two signatures.</p>	<p>i)Ensure that each resident has one copy of the medication chart and that GP documentation includes start and stop dates and administration times; and ii) ensure that staff sign for all medications at the time of administration.</p> <p>30 days</p>
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA Moderate</p>	<p>Hospital level residents have a documented care plan evaluation and interRAI assessment three monthly and rest home six monthly, undertaken by a registered nurse. Progress notes are documented each shift. Issues identified through progress notes reporting has not been followed through for all residents.</p>	<p>The progress notes for the tracer resident identified family concerns regarding pain. There is no documented followed up by an RN (noting that analgesia is charted and given), and RNs have mistakenly identified a boil as a pressure injury.</p>	<p>Ensure that concerns in progress notes are documented as followed up by an RN. Ensure that RNs are able to assess and correctly document the nature of wounds.</p> <p>60 days</p>

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, there 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.