

Lester Heights Hospital Limited - Lester Heights Hospital

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: 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: 3 April 2017 End date: 4 April 2017

Proposed changes to current services (if any): This audit included assessing the service for the provision of residential disability services.

Total beds occupied across all premises included in the audit on the first day of the audit: 29



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

Lester Heights Hospital and Residential Care is certified to provide rest home and hospital (geriatric and medical) level care for up to 35 residents. On the day of the audit there were 29 residents living at the facility.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, family, management and staff.

One of the two owners are on-site Monday to Friday. The experienced facility manager also oversees clinical care and is supported by registered nurses.

The residents and relatives interviewed spoke positively about the care and support provided at Lester Heights Hospital and Residential Care.

The shortfall identified in their previous audit relating to care planning has not been addressed.

This surveillance audit identified two high risk findings in service delivery. Other improvements are required in relation to: complaints management, quality data, internal audits, corrective actions, hazard register, adverse event reporting, education, care planning, assessments, interventions, evaluations, medication management and food temperature recordings.

Consumer rights

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Communication with residents and families is appropriately managed and recorded. Complaints are managed and residents and families are aware of the complaints process.

Residents and relatives interviewed state that the staff and management are approachable and available. Families interviewed confirmed that they are informed of changes in health status and incidents/accidents.

The service has in place an implemented complaints policy and procedure that aligns with Code 10 of the Code of Rights. Complaint forms are available at the entrance of the service.

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.		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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A facility manager is responsible for the day-to-day operations of the service and the provision of clinical care. The facility manager is supported by the registered nurses. Quality and risk management processes are documented. 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. There are documented human resources policies in place. An orientation programme is provided for new staff. A staff education and training programme is documented. Registered nursing cover is provided 24 hours a day, 7 days a week. There are adequate numbers of staff on duty to ensure residents are safe.

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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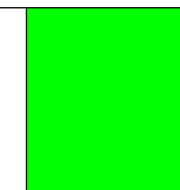
The registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family/whānau input.

An activities programme is in place. The programme includes outings, entertainment, activities and cultural days that meet the recreational preferences of the residents at the service. Residents expressed satisfaction with the activities provided.

Medication policies comply with legislative requirements and guidelines. Registered nurses responsible for administration of medicines complete education and medication competencies.

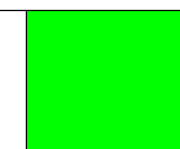
All meals are prepared on-site. Individual and special dietary needs are catered for. Residents and family/whānau interviewed responded favourably to the food that was provided.

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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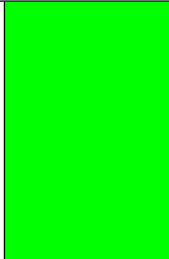
A current building warrant of fitness is posted in a visible location.

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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Lester Heights Hospital and Residential Care has restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit, there were eight residents with restraint and no residents with an enabler. Restraint management processes are adhered to.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection control surveillance programme is appropriate to the size and complexity of the service. 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	7	0	4	5	2	0
Criteria	0	25	0	7	7	2	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>	<p>PA Moderate</p>	<p>The complaints procedure is provided to residents and families during entry to the service. Access to complaints forms are located at reception and are accessible to all residents and families. Complaints forms include contact details for the Health and Disability Advocacy Service.</p> <p>Not all complaints received were documented on the complaints register. Seven complaints have been received in 2017 (year-to-date) from residents and or families. Documentation (including follow up) does not comply with the requirements of the Code.</p> <p>Discussions with residents and families/whānau confirmed they were provided with information on the complaints process.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive</p>	<p>FA</p>	<p>Residents interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Eight incidents/accidents forms were reviewed. The forms included a section to record family notification. All accident/incident forms reviewed indicated family were informed of an adverse event or evidenced that families did not wish to be informed. Relatives interviewed confirmed that they are notified of any changes in their family member's health status.</p>

to effective communication.		<p>All staff were observed wearing name badges.</p> <p>An interpreter service is available and accessible if required through the local district health board. Families and staff are utilised in the first instance.</p>
<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>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 29 residents living at the facility. Seven residents were receiving rest home level care including one resident on respite care. Twenty-two residents were receiving hospital level care including eight residents admitted on the young persons with disability contract and two residents on the long-term chronic condition contract. The service is currently not certified to provide residential disability care and the new owners were unaware of the requirements of applying for this. This audit included verifying the service as suitable to provide residential disability services – physical level care.</p> <p>An annual business plan has been developed that includes a philosophy, values and measurable goals that reflects a person centred approach.</p> <p>The service has completed a number of improvement projects since the last audit including installing CCTV cameras and upgrading the flooring in the dining area and resident's bedrooms. A new washing machine has been installed.</p> <p>One of the owners is on-site Monday to Friday to oversee the administrative functions of the business. One of the owners oversees the maintenance of the service. A facility/clinical manager with 20 years of nursing experience in aged care is responsible for all aspects of clinical care. Her title includes both facility and clinical management responsibilities. The facility/clinical manager receives support from the owners and a team of care staff that includes four RNs.</p> <p>The facility/clinical manager has completed at least eight hours of training related to management of an aged care facility, relevant to the role and responsibilities.</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</p>	PA Moderate	<p>A quality and risk management system is documented but not all aspects of the system are being implemented. Policies and procedures are maintained by an 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.</p> <p>Quality management systems are linked to internal audits, incident and accident reporting, health and safety reporting, infection control data and complaints management. Data is collected monthly but is not consistently analysed or trended and the results are not consistently communicated to staff. Corrective actions are not consistently documented, reviewed or communicated to staff.</p>

<p>principles.</p>		<p>A 2017 risk management plan is in place. Those residents admitted under the young people with a disability contracts have the opportunity to comment on the quality initiatives at the resident meetings and through the resident's surveys. Staff receive health and safety training during their induction to the service. A health and safety committee has been established. The committee meets quarterly and health and safety is an agenda item at all staff meetings (sighted). Actual and potential risks are documented on the hazard register, which identifies risk ratings and documents actions to eliminate or minimise the risk. There was no evidence of an annual review of the hazard register. A recent staff in-service was undertaken to address updates to health and safety legislation.</p> <p>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.</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>	<p>PA Low</p>	<p>An accidents and incidents reporting policy is in place. There was evidence of corrective actions documented on individual incident reports to minimise further injury (link 1.2.3.8). Clinical evaluation of residents following an adverse event is conducted by a registered nurse and was evidenced. However, not all residents had neurological observations completed following an unwitnessed fall (link 1.3.6.1).</p> <p>Adverse events are linked to the quality and risk management programme. Meeting minutes do not reflect that staff have been kept informed in a timely manner regarding accidents and incidents and the implementation of strategies to reduce the number of adverse events (link 1.2.3.6).</p> <p>The facility manager is aware of the requirement to notify relevant authorities in relation to essential notifications.</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>	<p>PA Low</p>	<p>Human resources policies are in place, including recruitment, selection, orientation and staff training and development. Six staff files reviewed (one facility manager, one RN, one cook, two healthcare assistants and one cleaner) included evidence of the recruitment process, signed employment contracts, police vetting and completed orientation programmes. Not all staff files reviewed, evidenced that a performance review had been completed at least annually. The orientation programme provides new staff with relevant information for safe work practice. Staff interviewed stated that they believed new staff were adequately orientated to the service. One of four registered nurses and the facility manager are interRAI trained.</p> <p>A register of current practising certificates for all health professionals is maintained.</p> <p>There is an annual education schedule in place, however this is not being implemented. Staff have not received training in relation to young people with disabilities.</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>	<p>FA</p>	<p>There is an organisational staffing policy that aligns with contractual requirements and includes skill mixes. The facility manager is an experienced RN who works full-time Monday – Friday. There is no specific clinical manager position. The registered nurses and the facility manager share the on call.</p> <p>There is a registered nurse and four healthcare assistants (two long and two short shifts) on an am shift. There is one registered nurse and four healthcare assistants (one long and three short shifts) on a pm shift. There is one registered nurse and one healthcare assistant on a night shift. Staff interviewed report that additional staff can be rostered on to meet the increased needs of the residents as required. There are dedicated laundry and cleaning staff that provide seven-day cover. The activity coordinator works a total of 30 hours per week Monday to Friday.</p> <p>Interviews with residents and families confirmed staffing overall was satisfactory.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>Ten medication charts were reviewed (four rest home- including one respite, six hospital- including two young people with disability and one long term chronic). There are policies available for safe medicine management that meet legislative requirements. Not all medication charts sampled met legislative prescribing requirements. The medication charts reviewed identified that the GP had reviewed all resident's medication three-monthly and allergies were noted.</p> <p>All clinical staff who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Staff were observed to be safely administering medications. Registered nurses interviewed could describe their role regarding medication administration. The service currently uses blister packed medications. All medications are checked on delivery against the medication chart and any discrepancies are fed back to the supplying pharmacy.</p> <p>The standing orders in use do not comply with the Standing Orders Guidelines 2016. There were no residents self-medicating on the day of audit.</p> <p>The medication fridge temperature is recorded regularly and these are within acceptable ranges.</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</p>	<p>PA Low</p>	<p>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. The cook receives a dietary profile of resident dietary requirements and any likes or dislikes. Special diets including modified foods are provided.</p> <p>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.</p>

<p>service delivery.</p>		<p>Food is plated in the main kitchen and served directly to the residents in the adjacent dining room. Food is served from a bain marie to the residents in the second dining room.</p> <p>Fridge, freezer and end-cooked temperatures are not being consistently monitored. A kitchen cleaning schedule is in place and implemented. Chemicals are stored safely within the kitchen.</p> <p>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.</p>
<p>Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>PA Moderate</p>	<p>In four of four long-term resident files sampled, there was evidence that appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. The interRAI assessment tool is implemented. Not all initial interRAI assessments had been completed in the required timeframes (link 1.3.3.3). Where interRAI assessments had been completed, there was evidence that the interRAI assessments had been reviewed at least six-monthly. Not all files sampled demonstrated the use of appropriate assessment tools where required.</p>
<p>Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA High</p>	<p>The interRAI and other appropriate assessments inform the development of the resident's care plan (link 1.3.4 2). The care plans are personalised and customer focused. The care plans sampled identified allied health involvement (link 1.3.3.4). Residents and their family/whānau interviewed reported that they are involved in the care planning and review process.</p> <p>Not all residents had a care plan. Short-term care plans were not evidenced for all changes in health status and care plans were not documented for all identified long-term care needs.</p> <p>The registered nurses are responsible for the development of discharge plans. Not all respite residents who had been discharged home from the service could evidence a discharge planning process.</p> <p>The previous audit finding around care planning remains.</p>
<p>Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and</p>	<p>PA Moderate</p>	<p>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.</p> <p>Adequate dressing supplies were sighted in the treatment room. Wound management policies and procedures are in place. There were five residents with wounds including one resident with a stage II non-</p>

<p>desired outcomes.</p>		<p>facility acquired pressure injury (tracer-young person with disability). 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.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management and continence products identified.</p> <p>Monitoring forms are used, for example: observations, weight, food and fluid, behaviour, blood sugar levels and neurological signs. Monitoring charts are not fully completed.</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>	<p>FA</p>	<p>The activity coordinator is employed for 30 hours per week Monday to Friday to coordinate and implement the activity programme. The maintenance man drives the van when they go on outings. Both 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.</p> <p>The programme is varied and interesting with board games, quizzes, reading, bowls, exercises and specific activities have been developed for Māori. Links with the community involve speakers, visiting children, Kapa Haka group, music entertainers and church services. There are outings into the community.</p> <p>Young people with disabilities are able to participate in a range of recreational, leisure, cultural and community events consistent with their preferences.</p> <p>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.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Low</p>	<p>All initial care plans reviewed were evaluated by the RN within three weeks of admission (link 1.3.5.2). In three of three long-term files sampled due for review, care plans have been reviewed at least six-monthly, however, the care plans were not always updated with a change in care needs. One long-term resident (YPD tracer) was new to the service and the LTCP had not been documented (link 1.3.5.2). 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.</p>
<p>Standard 1.4.2: Facility Specifications</p>	<p>FA</p>	<p>A current building warrant of fitness is posted in a visible location (expiry 4 December 2017).</p>

<p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		
<p>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.</p>	<p>FA</p>	<p>There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place appropriate to the complexity of service provided.</p> <p>The infection control coordinator collates information obtained through surveillance. The information is collated but not trended or analysed beyond the previous month's data and corrective actions were not consistently documented where improvements were required (link 1.2.3.6). Infection control data and relevant information is discussed at staff meetings. Individual infection reports were completed. Short-term care plans were not documented for the four infection reports randomly sampled from the March data (link 1.3.5.2).</p> <p>There have been no outbreaks since the last audit.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. Enablers are assessed as required for maintaining safety and independence and are used voluntarily by the residents. There are eight hospital residents requiring the use of restraints (three lap belts and five bed rails). There was one hospital resident requiring the use of an enabler (bedrails). Use of an enabler is voluntary. An assessment for restraint/enabler use and consent form were evidenced completed in the four restraint files reviewed. The care plans reviewed stated the risks associated with the use of restraint, but did not include interventions to manage the risks (link 1.3.5.2). Restraint audits and education have been completed.</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 1.1.13.1</p> <p>The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.</p>	<p>PA Moderate</p>	<p>The service has a complaints management policy that complies with the requirements of the Code. The service has complaint forms available throughout the facility which are placed so they are accessible to all residents. Information about the Code is also provided to residents and their family/whānau on admission.</p> <p>During the month of January, six allegations were made of elder abuse by family members or residents. The owners report each incident was investigated and the allegations were not substantiated. However, no record of the investigations was kept and no detailed record of the follow up was provided. Interviews with residents and relatives confirmed satisfaction with the care and support. There is a complaint register</p>	<p>i) Six of eight complaints received from residents or families (2017 year to date) were not responded to within the required timeframes and the complainants were not advised on how to contact the Health and Disability Commissioner.</p> <p>ii) Two resident complaints (one documented in the resident meeting minutes for January and one reported verbally to staff) were not documented on the complaints register and these complaints were not investigated or responded to.</p> <p>iii) There was no record kept of the investigations undertaken into the</p>	<p>i-iii) Ensure that all aspects of complaints management comply with the requirements of Right 10 of the Code.</p> <p>60 days</p>

		<p>in place which has also been used to document staff complaints. Not all complaints received by residents and families had been documented on the complaints register. The owners and facility/clinical manager (interviewed) were not aware of all complaints received. The owners described a process they used to investigate the complaints made by staff and by residents; however, no records were kept of the investigation process. The complaints were not managed within the required timeframes and complainants were not advised of the contact details for the Health and Disability Advocacy service. There was no evidence the complainants were contacted to see if they were satisfied with the outcome of the investigation or the management of the complaint.</p> <p>The complaints noted on the complaints register had not been trended or analysed (link 1.2.3.6).</p>	complaints made.	
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	<p>Clinical indicator data is collected each month for falls, skin tears, medication errors and infections. Accident and incident forms are completed by staff and collated (link 1.2.4.3). Complaints are documented on a register but have not been analysed for trends. The service has an audit schedule which has not been fully implemented (link 1. 2 .3.7). Where internal audits have been completed, corrective actions have not always been actioned where shortfalls are identified (link 1.2.3.8). Quality improvement data is not consistently trended and analysed to identify opportunities for improvement and the results are not communicated to staff.</p>	<p>There was no evidence that quality data (infection surveillance data, incidents and accidents, complaints, clinical indicator data) were being consistently analysed and trended and the results communicated to staff.</p>	<p>Ensure that all quality improvement data is trended and analysed and the results communicated to staff and residents where appropriate.</p> <p>90 days</p>

<p>Criterion 1.2.3.7</p> <p>A process to measure achievement against the quality and risk management plan is implemented.</p>	<p>PA Moderate</p>	<p>An internal audit programme is documented, but not all scheduled audits have been completed.</p>	<p>i) Seven of twelve audits scheduled from September through to March have not been completed (laundry, staff satisfaction, staff education, building compliance, resident admission process, resident file check and infection control).</p>	<p>Ensure that the monitoring schedule is fully implemented.</p> <p>60 days</p>
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	<p>PA Low</p>	<p>The service captures quality data. Where areas requiring improvements were noted, corrective action plans were not consistently documented. Where corrective action plans have been developed, these are not consistently evaluated and signed out.</p>	<p>i) Corrective action plans are not being consistently documented where the quality data is identifying areas requiring improvement.</p> <p>ii) Where corrective action plans have been documented, the corrective action plans are not being consistently evaluated, communicated to staff or signed out.</p> <p>iii) There was no evidence that the corrective action forms that are part of the service's quality management system are being used.</p>	<p>i-iii) Ensure that corrective actions plans are documented where opportunities for improvement are noted and the corrective action plans are then implemented, reviewed and signed off once completed.</p> <p>60 days</p>
<p>Criterion 1.2.3.9</p> <p>Actual and potential risks are identified, documented and where appropriate communicated to</p>	<p>PA Low</p>	<p>The service has documented health and safety policies. Health and safety is covered at orientation for new staff. The health and safety rep has attended training on health and safety. All staff are required to complete health and safety training at least annually and this was evidenced on the staff files sampled. Staff interviewed could describe</p>	<p>There is no evidence that the hazard register has been reviewed in the past 12 months.</p>	<p>Ensure that the hazard register is reviewed at least annually.</p>

<p>consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:</p> <p>(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;</p> <p>(b) A process that addresses/treats the risks associated with service provision is developed and implemented.</p>		<p>hazard management practices used on-site.</p> <p>There is a health and safety committee and health and safety is discussed at staff meetings.</p> <p>There is a hazard register in place, however there is no evidence of when the hazard register was last reviewed.</p>		<p>90 days</p>
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	<p>PA Low</p>	<p>The service has a policy in place that requires pressure injuries to be reported on an accident and incident form. One resident with a pressure injury (YPD tracer) did not have an incident form documented for the non-facility acquired pressure injury.</p>	<p>The non-facility acquired pressure injury was not documented on an accident and incident form or captured in the clinical indicator data.</p>	<p>Ensure that all pressure injuries are reported on an accident and incident form.</p> <p>90 days</p>
<p>Criterion 1.2.7.5</p>	<p>PA Low</p>	<p>The service has an annual education planner,</p>	<p>i) Six of the nine scheduled education</p>	<p>i) Ensure that</p>

<p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>		<p>which has not been fully implemented since September 2016. The service currently has eight residents admitted under a young person with disability contract. No training has been provided to staff about the needs of the younger person with a disability. Where education has been held, there has been good staff attendance. Each staff member has a record of the education they have attended, maintained in their individual file. Staff who administered medication have completed the required medication competencies. Staff who work in the kitchen have completed food safety training. There are staff on each shift that have been trained in first aid.</p> <p>Training provided since May 2016 includes: pressure injury prevention, infection control (outbreaks and hand washing), medication administration, chemical safety, cultural support, complaints and open disclosure, restraint, epilepsy, wound management and wound infections, health and safety April changes, Code of Rights, fire evacuation, informed consent, restraint and diabetes.</p>	<p>sessions between September 2016 and February 2017 have not been delivered.</p> <p>ii) Education has not been provided to staff on the needs of the younger person with a disability.</p> <p>iii) Six of six staff files sampled could not evidence completion of an annual performance review.</p>	<p>the education planner is fully implemented.</p> <p>ii) Ensure that staff are provided with education on the needs of the younger person with a disability.</p> <p>iii) Ensure that all staff have an annual performance review.</p> <p>90 days</p>
<p>Criterion 1.3.12.6 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>The general practitioner charts all medications to be administered- including alternative therapies. In the files sampled there is evidence that the GP reviews the resident's medication at least every three months. One respite resident had two medication prescribing charts in use- one hospital generated chart and one GP generated chart. One chart had Paracetamol charted QID and the other chart had Paracetamol charted up to QID as required. The GP had charted the same dose of anticoagulant twice, but neither charting was dated and signed.</p> <p>The service uses standing orders. However, the</p>	<p>i) One rest home resident (respite) had a) the same dose of anticoagulation therapy charted twice- one charting was not signed and the other charting was not dated and; b) the Paracetamol charted QID on one chart and Paracetamol PRN up to QID on the second chart.</p> <p>ii) Standing orders in use do not comply with Ministry of Health 2016 Standing Order Guidelines (2nd edition).</p>	<p>i-ii) Ensure that all medication is charted in accordance with all professional guidelines and legislative requirements.</p>

		standing orders in use do not consistently record the number of dose(s) of the medicine for which the standing order is valid, the contraindications and/or exclusions for the medicines, the monitoring of the medicine (if required), the clinical documentation to be recorded and the standing order competency requirements.		60 days
<p>Criterion 1.3.13.5</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p>	PA Low	The service has documented policies in place for the provision of safe food services. Staff who work in the kitchen have completed food safety handling courses. Staff are required to wear hats in the kitchen (observed). There are cleaning schedules in place. End cooked food temperature and fridge and freezer temperatures are not being consistently documented.	<p>(i) End cooked food temperatures are not being consistently documented.</p> <p>(ii) Fridge and freezer temperatures are not being consistently documented.</p>	<p>i-ii) Ensure that end cooked food temperatures and fridge and freezer temperatures are consistently documented.</p> <p>90 days</p>
<p>Criterion 1.3.3.1</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.</p>	PA Moderate	<p>The registered nurse completes the interRAI assessments and documents the care plans. Not all interRAI assessments or long-term care plans had been completed within the required timeframes. Not all care plans documented had been checked and signed by a registered nurse.</p> <p>The healthcare assistants (interviewed) advised they report changes in the resident's condition to the registered nurses and document the changes in the progress notes. Not all changes in the resident's condition reported by care staff, demonstrated follow up by a registered nurse in a timely manner.</p> <p>Monitoring charts were in use for but not limited to: weight, food and fluid, restraint and behaviours.</p>	<p>(i) One of five wound care plans sampled for a hospital resident, was documented by a student nurse and had not been reviewed or countersigned by a registered nurse.</p> <p>(ii) One rest home respite resident and two hospital residents had changes in health condition (pain, red skin areas, behaviours) reported in the progress notes by healthcare assistants. However, there was no documented evidence of follow up or follow up in a timely manner by a registered nurse.</p>	<p>(i) Ensure that a registered nurse reviews and signs off all assessments and care plans.</p> <p>(ii) Ensure that issues reported by healthcare assistants are followed up in</p>

		<p>Not all monitoring charts in use could evidence a review by a registered nurse.</p> <p>One rest home respite resident was accepted back to the facility from the DHB with a PICC line for IV antibiotics, to be managed by the district nursing service. There is no evidence that the staff received any training in the management of the PICC line.</p>		<p>a timely manner by registered nurses.</p> <p>60 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>The registered nurses are responsible for all aspects of assessment, care planning, service provision and review, within timeframes that safely meet the needs of the resident. Not all assessments or care plans had been developed within the required timeframes.</p>	<p>i) Two of two subsidised residents (one hospital and one rest home) admitted for long-term care did not have the interRAI assessment completed within 21 days of admission.</p> <p>ii) Four of four long-term residents (two hospital including one young person with disability, one long term chronic and one rest home) did not have the long-term care plan developed within 21 days of admission (completed between 2- 3 months). The YPD resident admitted with co-morbidities in January still did not have a LTCP in place (link 1.3.5.2).</p>	<p>i-ii) Ensure that all interRAI assessments and long-term care plans are documented within the required timeframes.</p> <p>30 days</p>
<p>Criterion 1.3.3.4</p> <p>The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.</p>	<p>PA High</p>	<p>The service uses an integrated resident file to store all clinical information for that resident, under various sectional dividers in one folder. There is also a separate wound care folder which is linked to the short-term wound care plan kept in a separate folder. Care staff document in the progress notes every shift. The registered nurses are required to document in the progress notes at least every 24 hours or more frequently with a change in care condition (link 1.3.3.1). There is a handover</p>	<p>In one rest home respite file, there was no documentation kept in the resident's file of the care provided by the district nursing service or of the assessments and consultations completed by the medical staff. The rest home respite resident was accepted for admission from the DHB with a PICC line that was to be managed by the district nursing service. There was no evidence that the registered nurses at</p>	<p>Ensure that a record is kept in the resident's file of all assessments and care provided by the allied health care</p>

		<p>between shifts (witnessed).</p> <p>One rest home respite resident had a PICC line managed by the district nursing service. No records of the care provided by the district nursing service was documented in the resident's records. The progress notes evidence that medical staff were consulted about the care of this respite resident. However, there was no documented evidence completed by the medical staff, of the medical consultations in the resident's clinical file.</p>	<p>Lester Heights had received any training in the monitoring required for the PICC line. The PICC line blocked after hours and the service was unable to access support from the district nurses. The resident had complex care requirements, was admitted 10 days prior to the audit and did not have: a) any assessments or care plans documented to manage the residents care needs and b) the interventions noted in the hospital discharge summary (review of INR, blood cultures and histology follow up) evidenced as completed or completed within the required timeframe.</p>	<p>team and the medical officers. Ensure that assessments and care plans are documented in a timely manner and the requirements noted in the hospital discharge summaries are completed in the timeframes stipulated.</p> <p>7 days</p>
<p>Criterion 1.3.4.2</p> <p>The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.</p>	<p>PA Moderate</p>	<p>Registered nurses complete a range of assessments on admission to inform the development of the care plan including (but not limited to): interRAI, skin and body map, Coombes, Waterlow and MNA. In the files sampled, not all residents on an ARRC contract had an interRAI assessment completed within the required timeframes (link 1.3.3.3). Not all residents reporting pain had pain assessments completed. One resident (YPD tracer) was initially admitted for a period of respite and then transferred to long-term care in January 2017. This resident was admitted with a stage II pressure injury and had not had a pressure risk assessment completed. Residents under other contracts did not have all assessments</p>	<p>(i) Four of four residents (two rest home- including one respite and two hospital- including one resident admitted under a long term chronic contract) documented episodes of pain in the progress notes, but there was no evidence of any pain assessments being completed.</p> <p>(ii) One YPD resident (hospital) and one LTCH resident (hospital) did not have all required assessments completed on admission.</p>	<p>(i)-(ii) Ensure that risk assessments including screening for PI risk and pain are completed where indicated.</p> <p>30 days</p>

		completed.		
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	PA High	<p>The registered nurses' complete assessments to identify the care needs of the resident and use this information to inform the development of the care plan (link 1.3.4 2). One rest home resident admitted for respite care from the DHB ten days before the audit with complex care needs, had no care plans documented. There was also no evidence of discharge planning for the three previous periods of respite since October. Initial care plans were evidenced in the files sampled, however not all initial care plans included interventions for all care needs.</p> <p>Not all interventions for assessed care needs were documented in the LTCPs in sufficient detail to guide the care staff. Interventions noted by the dietitian for a resident with weight loss were not transferred to the long-term care plan. There was evidence of the use of short-term care plans, however, short-term care plans were not used for all acute changes in care needs.</p> <p>The assessment and consenting process for the use of restraint identifies the risks associated with the use of the restraint. Not all restraint care plans documented the interventions required to manage the identified risks.</p>	<p>(i) One respite resident (rest home) admitted to the service on the 24 March, had no care plan documented and no evidence of a discharge planning process for the three previous admissions.</p> <p>(ii) One YPD hospital resident with co-morbidities admitted in January 2017 had an initial care plan documented but did not have a long-term care plan documented. The initial care plan for the YPD resident did have sufficient interventions to cover all current needs.</p> <p>(iii) Three of three long-term care plans (two hospital- including one resident long-term chronic and one rest home resident) did not have care plans documented for all identified needs. For example: a) the management of urosepsis; b) de-escalation strategies for behaviours; c) weight loss; d) Parkinson's symptoms; e) the risk of developing pressure injuries; and f) the management of seizures.</p> <p>(iv) Short-term care plans were not documented for: a) four of the four infections noted in the infection monitoring forms randomly selected from the March surveillance data; and b) in five of the five resident files sampled for (i) change in health condition; (ii) for the management of weight loss (rest home tracer) and (iii) infections.</p> <p>v) One resident (rest home) with weight loss, did not have the care plan</p>	<p>(i) Ensure care plans are documented for all respite residents. Ensure that all interventions noted by allied health are transferred to the care plan.</p> <p>(ii) Ensure that all residents have a long-term care plan documented to support current needs.</p> <p>iii-vi) Ensure that care plans are documented for all assessed care needs and updated as needs change.</p> <p>7 days</p>

			<p>documented by the dietician in the progress notes, transferred to the care plan.</p> <p>(vi) Three of three hospital residents using restraint did not have interventions documented in the care plan to manage the risks associated with the use of the restraint that were identified in the assessment and consenting process.</p>	
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA</p> <p>Moderate</p>	<p>The RN reviews information gathered from assessments, monitoring charts, observations and interviews with residents, staff and families to document the interventions required in the care plan. The care plan describes the type and frequency of monitoring the resident requires. Not all monitoring charts in use were fully completed or evidenced a review by the registered nurse. Not all restraint care plans documented the interventions in sufficient detail to manage the risks associated with the use of the restraint identified in the assessment and consenting process.</p>	<p>i) Two residents (one rest home and one hospital- long term chronic) on behaviour monitoring charts did not have all sections of the monitoring form completed and did not evidence review of the monitoring by a registered nurse.</p> <p>ii) Four of four residents (two rest home and two hospital) did not have neurological observations completed or completed for the required timeframes.</p> <p>iii) Four of eight hospital residents using a restraint did not have interventions to manage the risks documented in sufficient detail to guide the care staff.</p>	<p>i) Ensure that all sections of the behaviour monitoring form are fully completed and the behaviour monitoring form is reviewed by a registered nurse.</p> <p>ii) Ensure that all residents following an unwitnessed fall, have neurological observations completed in accordance with the organisations falls management</p>

				<p>policy.</p> <p>iii) Ensure that all residents using a restraint have interventions documented in sufficient detail to guide the care staff.</p> <p>60 days</p>
<p>Criterion 1.3.8.3</p> <p>Where progress is different from expected, the service responds by initiating changes to the service delivery plan.</p>	PA Low	<p>In the files sampled there was evidence that the long-term care plans had been evaluated at least six-monthly in conjunction with a review of the interRAI assessment. Not all changes in care needs noted in the evaluation were transferred to the interventions in the long-term care plan.</p>	<p>Two of three (hospital) care plans sampled were not updated with a change in care needs including a) an increase in the assistance required with meals; b) the removal of a restraint; and c) the development of a chronic infection.</p>	<p>Ensure that the care plan is evaluated and updated with all changes in care needs.</p> <p>90 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.