

Lester Heights Hospital Limited - Lester Heights Hospital

Introduction

This report records the results of a Certification 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); Residential disability services - Physical
Dates of audit:	Start date: 31 August 2017 End date: 1 September 2017
Proposed changes to current services (if any):	
Total beds occupied across all premises included in the audit on the first day of the audit:	28

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
Yellow	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
Red	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, hospital (geriatric and medical) and residential disability levels of care for up to 35 residents. On the day of the audit there were 28 residents living at the facility.

This audit was conducted against the health and disability service standards, the district health board contract and ministry of health contract. A developmental evaluation was also conducted at the same time as the certification audit and reviewed services for younger people with a disability. 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 manager (owner) is supported by a director with rest home management experience, a clinical manager who is a registered nurse and a contracted quality/clinical consultant. The service was managed by a statutory manager between 12 April 2017 and 28 June 2017. The previous statutory manager is now the contracted consultant for the service. Residents and family interviewed were complimentary of the service they receive.

This audit identified that an improvement is required around notifying families of incidents and 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.		Some standards applicable to this service partially attained and of low risk.
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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 and addressed. 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

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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Services are planned, coordinated, and are appropriate to the needs of the residents. Quality and risk management processes have been implemented since the previous audit. Quality goals are now 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 now 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

<p>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.</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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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

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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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

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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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, eight residents (hospital level) were using restraints and three residents were using enablers. Staff have received education and training on restraint minimisation.

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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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	0	48	0	1	1	0	0
Criteria	0	99	0	1	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](#).

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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>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 manager [owner] one director, one clinical manager, one registered nurse lead, four healthcare assistants, two registered nurses (RN), one kitchen manager, one activities coordinator, one receptionist, 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 and through the staff education and training programme.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>There are established informed consent policies/procedures and advanced directives. General consents including photographs were obtained on admission and sighted in eight of eight resident files reviewed (three hospital residents including one on a long-term support chronic health condition, four young persons with disabilities and one rest home level resident). 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.</p> <p>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</p>

		<p>and informed decisions. The healthcare assistants (HCAs) and registered nurses interviewed demonstrated a good understanding in relation to informed consent and informed consent processes.</p> <p>Family and residents interviewed confirmed they have been made aware of and fully understand informed consent processes and that appropriate information had been provided. Seven of eight (one hospital resident awaiting PPPR signatory) admission agreements reviewed had been signed.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>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.</p> <p>Staff have received education and training on the role of advocacy services, which begins during their induction to the service and has been provided in 2017.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>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.</p> <p>Where possible there are good links between the young residents with disabilities and their family. Some families are very involved and others to a much lesser extent. Families stated feeling welcome whenever they visit the facility. There are few links with the community other than general outings. The complex medical needs of this group preclude any meaningful community engagement.</p>
<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>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.</p> <p>A record of all complaints received since the previous audit (four complaints) has been maintained by the owner/manager with the support of the quality/clinical consultant, since the last audit using a complaint's register. All four complaints were reviewed and documentation including follow-up letters and resolution demonstrates that complaints are now well-managed. All lodged complaints were resolved. There have been two complaints involving the district health board since the last audit. One has been resolved and the service only received notification of the other the day before the audit. This second complaint was about wheelchair maintenance and the wheelchair identified was in the process</p>

		<p>of being repaired during the audit.</p> <p>Discussions with residents and families confirmed they were provided with information on the complaints process and remarked that any concerns or issues they had were addressed promptly.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>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 eleven residents (four rest home level, four younger people with disabilities (YPD) and three hospital level) and seven family (one rest home level, four YPD and two hospital level) interviewed, reported that the residents' rights were being upheld by the service.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The residents' personal belongings are used to decorate their rooms. Privacy signage is on communal toilet and shower doors. All residents' rooms are currently single occupancy.</p> <p>The healthcare assistants (HCAs) 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.</p> <p>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 and has been provided since the last audit. The service had identified issues around abuse and the perpetrators have been identified and no longer work at the service.</p> <p>Family members and the young people with disabilities that were interviewed stated they are being treated well, and with respect. Each person has their own private room and their own belongings. These young residents have complex needs and whilst services are not aimed towards independence they do reflect the wishes of the residents.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability</p>	FA	<p>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. 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.</p>

<p>needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>		<p>Specific Māori cultural needs are identified on the cultural assessment and are linked to the Māori residents' care plans (evidenced in two of two Māori residents' files reviewed). Two residents and two family, all who identified as Māori, reported that their cultural needs were being met by the service.</p> <p>Māori consultation is sought internally and externally by the service. Several care staff identify as Māori and two staff have qualifications in Māori health. Staff education on cultural awareness begins during their induction to the service and has been provided in 2017. The healthcare assistants interviewed provided examples of how they ensure Māori values and beliefs are upheld by the service.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>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 care plans reviewed. 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.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>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.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>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.</p> <p>Resident/family meetings have begun to be conducted regularly, led by the activities coordinator. Residents and family/whānau interviewed reported that they are now either satisfied or very satisfied with the services received. A resident/family satisfaction survey was completed in May 2017 and identified satisfaction or high levels of satisfaction with the services received.</p> <p>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.</p>

		The GP interviewed is satisfied with the care that is now being provided by the service.
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	PA Low	<p>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 management and staff interviewed understood about open disclosure and providing appropriate information and resource material when required.</p> <p>Families interviewed confirmed they are kept informed of the resident's status, including any events adversely affecting the resident, although evidence of open disclosure by notifying family after an adverse event and/or through the incident/accident system is not consistently being documented.</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. The communication needs of younger people are identified and addressed. One younger resident has a communication board. The service has used a sign language interpreter for one younger resident, including assisting them to complete a satisfaction survey. The sign language interpreter has provided an education session for staff and posters with basic signs are displayed for staff to use.</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 28 residents living at the facility. This included seven residents receiving rest home level care (all under the ARCC) and 21 residents receiving hospital level of care – 10 under the ARCC, nine younger people with disabilities and two on long-term support – chronic health conditions contracts.</p> <p>A 2017 business plan has been developed with specific goals to enable the service to move forward and continue to improve the service provided to residents. The plan identified the purpose, values, scope and direction of Lester Heights. The plan includes specific goals to ensure the needs of younger people in the service are met.</p> <p>Lester Heights Hospital is the only facility owned by the current manager. He has had little previous experience managing an aged care facility, but his wife, who is now a director, has sold the facility she previously owned and is now working full time at the service as a director. Additionally, the statutory manager who managed the facility from 12 April 2017 to 28 June 2017 has been contracted to provide clinical and quality support for two days per week. The manager, director and quality/clinical consultant all reported that it is intended that this contract will continue for the foreseeable future until the service is well established and providing best practice without the input of the consultant. Additionally, there is an experienced clinical manager and a registered nurse lead that provides support to the clinical manager</p>

		<p>and in a quality role.</p> <p>The owner/manager has received ongoing mentoring and professional development related to managing an aged care facility since the last audit, from the quality/clinical consultant.</p>
<p>Standard 1.2.2: Service Management</p> <p>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.</p>	FA	<p>The manager reported that in his absence the director would undertake the management role and if both were absent the clinical manager would fill the role with support from the registered nurse lead.</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>A quality and risk management plan has been developed since the previous audit and the quality and risk management system has been fully implemented since this time. A complete new set of policies and procedures (and clinical documentation) have been developed by the quality/clinical consultant. These include a number of policies specific to younger people residing in an aged residential care environment and align with current good practice and meet legislative requirements.</p> <p>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 areas). Corrective actions are documented and implemented where improvements are identified. Information is shared with all staff as confirmed in meeting minutes and during interviews.</p> <p>Staff, residents and family/whānau interviews confirmed any concerns they have were addressed by management, and examples of quality initiatives were provided.</p> <p>A 2017 risk management plan is in place. Staff receive health and safety training, which is initiated during their induction to the service. Actual and potential risks are documented in the hazard register, which identifies a risk rating and shows actions to eliminate or minimise the risk. This includes risks around restraint use.</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>FA</p>	<p>There is an incident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise future events and debriefing. 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. Ten accident/incident forms were reviewed. Each event involving a resident reflected a clinical assessment and follow-up by a registered nurse. Neurology observations were conducted for suspected head injuries. Accident/incident forms for pressure injuries have been consistently completed.</p> <p>The manager/owner and quality/clinical advisor reported that they are aware of their responsibility to notify relevant authorities in relation to essential notifications. One notification has been made via section 31 when a family member struck a resident.</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>FA</p>	<p>There are human resources policies in place, including recruitment, selection, orientation and staff training and development. Seven staff files reviewed (one clinical manager, the RN lead, three healthcare assistants, the activities coordinator and the kitchen manager) 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.</p> <p>A register of current practising certificates for all health professionals is maintained.</p> <p>There is an annual education schedule that is now being implemented. All required education has been provided in the past year. In addition, opportunistic education is provided. Staff received comprehensive training around meeting the varied needs of younger people living in an aged residential care environment in July 2017. Two of four RNs have completed their interRAI training.</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</p>	<p>FA</p>	<p>There is an organisational staffing policy that aligns with contractual requirements and includes skill mixes. One RN is on duty 24 hours a day, seven days a week. This includes either the clinical manager or the registered nurse lead on morning shift. The Clinical Manager has three days and the registered nurse lead has two days when they are not on the floor and undertake quality activities. (40 hours dedicated to quality initiatives/activities in total).</p> <p>The healthcare assistant roster is as follows:</p>

providers.		<p>AM shift: Three healthcare assistants full shift, one healthcare assistant until 1 pm.</p> <p>PM shift: One healthcare assistant full shift, two healthcare assistants until 7 pm.</p> <p>Night shift: One healthcare assistant.</p> <p>Staffing is flexible to meet the acuity and needs of the residents. Interviews with staff, residents and families confirmed staffing overall was satisfactory.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>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. 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.</p> <p>Residents' files demonstrate service integration. Entries are legible, dated, timed and signed by the relevant healthcare assistant or nurse, including designation.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>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.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>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.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in</p>	PA Moderate	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Registered nurses that administer medications have been assessed for competency. Registered nurses complete syringe driver training via hospice. Education around safe medication</p>

<p>a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>administration has been provided. Medications received (robotic rolls), are checked on delivery by the RN. Standing orders were current (last reviewed and signed by GP and RN April 2017) and met the legislative requirements around standing orders. There was one hospital resident self-medicating on the day of audit and a competency assessment had been completed and was current. Younger residents (YPD) are able to self-medicate if deemed appropriate. None were self-medicating at the time of the audit. All medications were stored safely. All eye drops were dated on opening. There were no expired medications on the day of audit. The medication fridge is monitored daily (temperatures sighted).</p> <p>All 12 medication charts reviewed (six hospital, two rest home and four YPD) met legislative prescribing requirements (included one hospital resident on warfarin), had photographic identification and allergies documented and were legible. Not all medication charts had all medications signed as administered. The GP has reviewed the medication charts three-monthly.</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 Lester Heights are prepared and cooked on-site by a qualified cook.</p> <p>All staff have attended food safety and hygiene training. There is a four-weekly seasonal menu, which had been reviewed by a dietitian in June 2017. The service accommodates cultural food preferences for Māori with Māori dishes provided on the menu. The service caters for other cultures upon request. The cook interviewed was knowledgeable about resident dietary requirements and receives a resident dietary profile and any likes or dislikes. Special diets including modified foods are provided.</p> <p>Staff were observed assisting residents with their meals and drinks at lunchtime. A smaller dining room/lounge is used to maintain the dignity of residents requiring additional assistance. Special equipment is available and was observed in use.</p> <p>Fridge, freezer and end-cooked temperatures (sighted) are monitored daily. 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, provides resident feedback on the meals and food services. Residents and family members interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to</p>	<p>FA</p>	<p>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 communicates directly with the referring agencies and family/whānau as appropriate if entry was declined.</p>

the consumer and/or their family/whānau is managed by the organisation, where appropriate.		
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 in all long-term resident files sampled. In resident files sampled, long-term care plans in place reflected the outcomes of the assessments.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Resident files reviewed were resident focused and individualised. Identified support needs as assessed were included in the care plans for all resident files sampled. 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 sampled demonstrated service integration and evidence of allied health 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. RNs interviewed could describe the process and documentation required for managing 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	Interventions for residents including the young people with disabilities are consistent, and relevant to the goals that are set, in relation to their needs. When a resident's condition alters, the registered nurse initiates a review and if required a GP or nurse specialist consultation. 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 one chronic ulcer, one skin lesion, one moisture lesion, one loose toenail and three residents with pressure injuries (all grade two facility acquired). All wound plans were signed off by the RN. 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

		<p>as infections.</p> <p>Monitoring forms are used, for example, observations, weight, food and fluid, behaviour, blood sugar levels and neurological signs.</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>The activity coordinator (also the Māori Liaison officer) is employed for 30 hours per week Monday to Friday to coordinate and implement the activities programme. She is supported by a volunteer and HCAs who provide assistance with some activities and outings. A van is hired for outings. There is an integrated 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 residents meet quarterly at resident meetings and with assistance from the activities coordinator develop the activities programme. The programme includes; bingo, quizzes, bowls, exercises, arts and crafts, mosaics, pampering and weekly outings. Specific activities have been developed for Māori (included in the individual Māori care plan). Links with the community involve Kaumātua, speakers, visiting children, Kapa Haka group, music entertainers and church services. There are outings into the community and inter-home visits.</p> <p>Activities for the young people with disabilities are not different to those of the other residents. Due to the complexity of this group's needs, most are unable to participate in a variety of activities. Two of the young residents prefer not to participate in the older residents' activities and staff have worked hard to include them, for example one of these residents is now helping the coordinator, and by doing this participates. One person is more interested in electronic games and technology.</p> <p>A social history and activity plan is completed on admission in consultation with the resident/family (as appropriate) and reviewed six-monthly. There is a specific Māori care plan. 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>	FA	<p>All initial care plans reviewed were evaluated by the RN within three weeks of admission. In six of the eight files sampled (one resident had been in the facility five months and the other was a new admission), the long-term care plans have been reviewed at least six-monthly or earlier for any health changes. The sample was extended by three (one hospital and two rest home) residents who had been at the facility longer than three months to capture more evaluations and all LTCPs had been reviewed six-monthly or sooner. All written evaluations reviewed, document the resident's progress against identified goals. RNs interviewed could describe the process and documentation required when completing resident evaluations. The GP reviews the residents at least three-monthly or earlier if required. Ongoing nursing evaluations occur as indicated or when there is a change in condition and are documented within the progress notes. There was evidence in the files sampled that STCPs had</p>

		been either signed off once resolved or transferred to the LTCP.
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>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.</p> <p>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.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Material safety datasheets are readily accessible for staff. Chemical bottles sighted had 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.</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>The building has a current building warrant of fitness that expires 1 December 2017.</p> <p>The owner is the maintenance person and he ensures daily maintenance requests are addressed and a planned maintenance schedule is maintained. There is a planned (sighted) maintenance repair list the maintenance person is working through. There is an ongoing refurbishment/refresher of bedrooms as they become vacant and all 35 resident rooms have all had new linoleum laid. Linoleum has been installed in bathrooms. A carpet replacement plan is in progress and there has been some landscaping of gardens. A retaining wall has been constructed on the south side of the property. A mechanical fire (HCVA) system has been installed which allows for toilet, and kitchen hood ventilation with smoke spill fan system. 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. Electrical test and tag checks on all facility and resident electrical equipment had been completed August 2017.</p> <p>Annual calibration and functional checks of medical equipment is completed by an external contractor,</p>

		<p>last in August 2017.</p> <p>The facility has wide corridors with sufficient space for residents to safely mobilise using mobility aids.</p> <p>There is safe access to the outdoor areas. Seating and shade is provided. There is a designated outdoor smoking area.</p> <p>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.</p> <p>Younger residents have rooms throughout the facility and share the same communal areas as other residents. Those interviewed felt this was satisfactory.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>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.</p>	FA	<p>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.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>There are 35 single rooms. 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.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and</p>	FA	<p>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. YPD residents interviewed stated they enjoyed living in the home and their needs including privacy were respected.</p>

dining needs.		
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>There are adequate policies and procedures for the safe and efficient use of laundry services. There is a dedicated laundry manager and cleaning staff cover a seven day a week service. 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 three sluice rooms with personal protective equipment readily available.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>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 includes fire and security training. Staff interviewed confirmed their understanding of emergency procedures. A mechanical HVCA fire system is in place.</p> <p>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 and sighted.</p> <p>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.</p> <p>There is a minimum of one staff member available 24 hours a day, seven days a week with a current first aid/CPR certificate. The activities coordinator also holds a current first aid/CPR certificate.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>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.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment,</p>	FA	<p>The clinical manager 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.</p>

which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.		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 registered nurse is the infection control coordinator. She has completed the infection control certificate in June 2017. 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, the 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 2017) 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	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

<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>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.</p> <p>There have been no outbreaks.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The restraint policy includes the definitions of restraint and enablers. Interviews with the restraint coordinator (clinical manager) and staff confirmed their understanding of restraint minimisation.</p> <p>At the time of the audit, eight residents (hospital level) were using restraints and three residents were using enablers. Enablers are assessed as required for maintaining safety and independence and are used voluntarily by the residents.</p> <p>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.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>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.</p>	FA	<p>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 restraint coordinator. A restraint committee, which includes the clinical manager, RN lead, senior healthcare assistant and GP, meets three-monthly. There were eight residents using restraints and three residents using enablers.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is</p>	FA	<p>The restraint coordinator (the registered nurse lead) 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</p>

undertaken, where indicated, in relation to use of restraint.		enablers that identify the risks of using restraint and the interventions used as an alternative to restraint. Three hospital level residents' files (including one YPD resident) where restraint was being used, were selected for review. Each file included a restraint assessment that included a restraint risk assessment. Assessments were completed before restraint was 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. 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 and the times the monitoring occurred, evidenced in all three residents' files where restraint was being used. All three residents' files reflected the use of restraint in the residents' restraint care plan including managing the risks posed for the resident by the use of restraint.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	Restraint use is formally reviewed on an evaluation form three-monthly (at a minimum) by the restraint coordinator, and meets requirements of the standard. When restraint is initiated, reviews take place with greater frequency. All residents on restraint are discussed at the weekly management meeting.
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 weekly management 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)
<p>Criterion 1.1.9.1</p> <p>Consumers have a right to full and frank information and open disclosure from service providers.</p>	PA Low	The staff and management interviewed were aware of the importance of open disclosure and reported ways the ensure this. Eight of ten incident forms sampled indicated this had occurred.	Two of ten incident forms sampled and the corresponding resident files do not document that family were informed of incidents.	<p>Ensure family are informed of all incidents and that this is documented.</p> <p>90 days</p>
<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</p>	PA Moderate	Resident medication charts are identified with demographic details, allergies and photographs. Medications are checked against the doctor's medication chart prior to administration. The medication round was observed at lunchtime and all practice was appropriate. Nine of twelve medication charts sampled	Three of twelve medication charts sampled (two hospital and one YPD) had prescribed	Ensure documentation reflects that medications are administered

<p>comply with legislation, protocols, and guidelines.</p>		<p>had all prescribed medications signed as administered.</p>	<p>medications that were not signed as administered.</p>	<p>as prescribed. 30 days</p>
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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.