

St John's Parish (Roslyn) Friends of the Aged and Needy Society - Leslie Groves 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:	St John's Parish (Roslyn) Friends of the Aged and Needy Society
Premises audited:	Leslie Groves Hospital
Services audited:	Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Dementia care
Dates of audit:	Start date: 11 July 2018 End date: 12 July 2018
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	68



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

Leslie Groves home and hospital is operated by the St John's Parish (Roslyn) Friends of the Aged and Needy Society and cares for up to 71 residents requiring hospital level, psychogeriatric and dementia level care. On the day of the audit there were 68 residents.

This certification audit was conducted against 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, relatives, management, staff and the general practitioner.

The residents, relatives and general practitioner spoke highly of the care and service provided at Leslie Groves Hospital. The service has a well-established quality system that identifies ongoing quality improvement.

The chief executive is a registered nurse and is experienced and qualified for the role. She is supported by a quality manager (registered nurse), a clinical nurse manager in the psychogeriatric unit and an acting clinical nurse manager in the hospital unit.

This audit has identified an area for improvement around incident management and weight management care plan interventions.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The staff at Leslie Groves ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and services is easily accessible to residents and families. Information on informed consent is discussed with residents (where able) and relatives and documented. Staff interviewed were familiar with processes to ensure informed consent. Complaints and concerns have been managed and a complaints register is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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An experienced chief executive officer (CEO) has managed the facility for 15 years. She is supported in her role by a quality services manager and two clinical nurse managers (CNMs). Quality management processes are reflected in the businesses plans, goals, objectives and policies. Corrective actions are identified and implemented. There is a current operations plan in place. A risk management programme is in place, which includes incident and accident reporting and health and safety processes. Staff document incidents and accidents. There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant

information for safe work practice. The service has an annual training schedule for in-service education. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

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 low risk.</p>
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There is information available for residents and relatives prior to entry to the service. Residents are assessed prior to entry to the service. Care plans are individually developed with the resident, and family/whānau involvement is included where appropriate and evaluated six monthly or more frequently when clinically indicated. Risk assessment tools and monitoring forms are available to assess effectively the level of risk and support required for residents. Activities are provided that are meaningful and ensure that the resident maintains involvement in the community. Medication management policies and procedures meet current guidelines. All staff who administer medications have completed annual competencies for medication administration. There are three monthly GP medication reviews. Food services are contracted to a food service company who work from the Leslie Groves hospital site kitchen and transport meals to the rest home. The menu is designed by a dietitian with summer and winter menus. Dietary requirements are provided where special needs are required.

Safe and appropriate environment

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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Leslie Grove Rest Home and Hospital have a current building warrant of fitness. Reactive and preventative maintenance is carried out. Medical equipment and electrical appliances have been calibrated. There is a designated laundry at the hospital site which includes the safe storage of cleaning and laundry chemicals. Residents' rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. There are sufficient communal areas within the hospital and the two dementia areas that include lounge and dining areas, and smaller seating areas. The service has implemented policies and procedures for civil defence and other emergencies and six-monthly fire drills are conducted. External garden areas are available with suitable pathways, seating and shade provided.

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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There is a restraint policy that includes the provision of a non-restraint environment. A register is maintained with all residents with enablers. There were six residents documented as using enablers. Staff are trained in 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 and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The quality manager is also the infections control coordinator. The infection control coordinator has attended external education and coordinates education and training for staff. There is a suite of infection control policies and guidelines to support practice. Information obtained through surveillance is used to determine infection control activities and education needs within the facility.

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	43	0	2	0	0	0
Criteria	0	91	0	2	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Discussions with staff (six caregivers including one from the psychogeriatric unit, one from the dementia unit and four from the hospital, one enrolled nurse from the dementia unit, two registered nurses both from the hospital unit, one clinical nurse manager (CNM) from the psychogeriatric unit and one acting CNM from the hospital unit, two diversional therapists – one from the hospital and one from the dementia unit, the chief executive and the quality manager) confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Seven residents from the hospital and four relatives (two from the psychogeriatric unit and two from the hospital) were interviewed and confirmed the services being provided are in line with the Code.</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</p>	FA	<p>There are established informed consent policies/procedures and advanced directives. General consents are obtained on admission. Specific consents are obtained for specific procedures such as influenza vaccine. Nine resident files (four hospital, three psychogeriatric and two dementia) sampled, contained signed general consents.</p> <p>Resuscitation status had been signed appropriately. A CPR treatment plan is available in the form of a flow chart outlining staff responsibilities and management of resuscitation.</p> <p>An informed consent policy is implemented. Systems are in place to ensure residents, and where</p>

<p>informed consent.</p>		<p>appropriate their family/whānau, are provided with appropriate information to make informed choices and informed decisions. The caregivers interviewed demonstrated a good understanding in relation to informed consent and informed consent processes. Four family and seven residents interviewed confirmed they have been made aware of and fully understand informed consent processes and that appropriate information had been provided.</p> <p>Nine resident files reviewed had signed admission agreements. Signed EPOA were on resident files where required.</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>	<p>FA</p>	<p>Client right to access advocacy and services is identified for residents. Advocacy leaflets are available in the service entrance area. The information identifies who the resident can contact to access advocacy services. The information pack provided to residents prior to entry includes advocacy information. Staff were aware of the right for advocacy and how to access and provide advocate information to residents if needed. Residents and family members interviewed were aware of their access to advocacy services.</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>	<p>FA</p>	<p>Residents and relatives interviewed confirmed that visiting can occur at any time. Key people involved in the resident's life have been documented in the care plans in files sampled. Residents and relatives interviewed verified that they have been supported and encouraged to remain involved in the community. Entertainers have been invited to perform at the facilities.</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>	<p>FA</p>	<p>A complaints policy and procedure have been implemented and residents and their family/whānau have been provided with information on admission. Complaint forms are available at the entrance of the service. Staff are aware of the complaints process and to whom they should direct complaints. A complaints folder has been maintained. Fifteen complaints were received in 2017 and seven in 2018 (YTD). These were reviewed and show appropriate acknowledgement, investigation and resolution within required timeframes. One complaint investigated by the Health and Disability Commissioner Systems has been completed with no finding of a breach of the code. Processes are in place to ensure that any complaint received is managed and resolved appropriately. Residents and family members interviewed advised that they are aware of the complaints procedure and how to access forms.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>The Code and advocacy pamphlets are located at the main entrance of the service. On admission, the CNM discusses the information pack with the resident and the family/whānau. This includes the Code, complaints and advocacy information. The service provides an open-door policy for concerns/complaints. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Residents and relatives interviewed identified they are well informed about the Code.</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>	<p>FA</p>	<p>Staff interviewed were able to describe the procedures for maintaining confidentiality of resident records, residents' privacy and dignity. A confidentiality agreement is signed by staff at commencement of employment.</p> <p>Church services are held weekly alongside regular Catholic communion and resident files include cultural and spiritual values. Contact details of spiritual/religious advisors are available to staff.</p> <p>Residents and relatives interviewed reported that residents are able to choose to engage in activities and access community resources. There is a prevention of abuse and neglect policy and staff education and training on abuse and neglect has been provided.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<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. They value and encourage active participation and input of the family/whānau in the day-to-day care of the resident. There are no current residents who identify as NZ Māori living at the facility. The service has a Māori health plan and a cultural safety policy which includes cultural safety and awareness. The service has established links with local Māori and staff confirmed they are aware of the need to respond appropriately to maintain cultural safety. Staff receive education on cultural awareness during their induction to the service and as a regular in-service topic. Discussions with staff confirmed their understanding of the different cultural needs of residents and their whānau.</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,</p>	<p>FA</p>	<p>The service identifies the residents' personal needs and values from the time of admission. This is achieved with the resident, family and/or their representative. Cultural values and beliefs are discussed and incorporated into the residents' care plans. All residents and relatives interviewed confirmed they were involved in developing the resident's plan of care, which included the identification of individual values and beliefs. There is multi-cultural staff employed at Leslie Groves hospital and rotating pictorial displays of other cultures are included in the activities programme. Caregivers interviewed could describe learning about their residents and cultures.</p>

spiritual values, and beliefs.		Relatives reported that they feel they are consulted and kept informed and family involvement is encouraged.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	A staff code of conduct is discussed during the new employee's induction to the service. Code of conduct training is also provided through the in-service training programme. Policy and procedures related to discrimination ensure residents receive services free from any discrimination, and that residents are not subjected to any form of coercion, harassment, sexual or other exploitation. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues. Interviews with caregivers and registered nurses confirmed their understanding of professional boundaries, including the boundaries within their roles and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings, and performance management if there is infringement with the person concerned.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	<p>The service meets the individualised needs of residents with needs relating to hospital (geriatric and medical), dementia and psychogeriatric level care. The quality programme has been designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Staffing policies include pre-employment, the requirement to attend orientation and ongoing in-service training. The quality manager is responsible for coordinating the internal audit programme. Monthly quality meetings, staff unit meetings, clinical meetings and regular residents' meetings are conducted. There is a regular in-service education and training programme for staff. Staff interviewed stated that they feel supported by the registered nurses and management team.</p> <p>Evidence-based practice is evident, promoting and encouraging good practice. A rotating on call roster is shared between the chief executive, quality manager and clinical nurse managers. A house general practitioner (GP) visits the facility twice weekly and a nurse practitioner is available on request for mental health support. The service receives support from the local district health board (DHB). Physiotherapy services are provided on-site, two to four hours per week. A podiatrist comes on site as required for referrals. The service has links with the local community and encourages residents to remain independent. Residents and relatives interviewed spoke positively about the care and support provided.</p>
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment	FA	<p>Policies and procedures relating to accident/incidents, complaints and open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. Management interviewed described an open-door policy.</p> <p>Evidence of communication with family/whānau is documented and held in each resident's file.</p>

<p>conducive to effective communication.</p>		<p>Accident/incident forms have a section to indicate if next of kin have been informed (or not) of an accident/incident. A sample of 18 accident/incident forms reviewed (ten hospital, five dementia, three psychogeriatric) from June and July 2018, all identified that family were kept informed. All relatives interviewed stated that they are kept well-informed when their family member's health status changes. Residents and family members also stated they were welcomed on entry and were given time and explanation about services and procedures. Resident/relative meetings occur two monthly.</p> <p>The service has policies and procedures available for access to interpreter services for residents (and their family/whānau). If residents or family/whānau have difficulty with written or spoken English, the interpreter services are made available.</p> <p>Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so.</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>	<p>FA</p>	<p>Leslie Groves is owned and operated by the St John's Parish (Roslyn) Friends of the Aged and Needy Society. The board meets monthly and provides a governance role. The service provides care for up to 71 residents at hospital (geriatric and medical), psychogeriatric and dementia level care. On the day of the audit, there were 68 residents in total (30 residents [including one resident on an end-of-life contract] in the 31-bed hospital unit, 17 residents in the 17-bed dementia unit, and 21 residents in the 23-bed psychogeriatric unit).</p> <p>The service is managed by an experienced chief executive (RN) who has been in the role for 15 years. The chief executive also provides oversight to their sister site (Leslie Groves rest home). The chief executive reports monthly to the board (or more frequently). She is supported by a quality manager (registered nurse) and two clinical nurse managers (one of whom is in an acting position).</p> <p>The 2018 strategic plan and operation/quality plan are being implemented. Goals include (but not limited to); extending benchmarking with external provider and improving care planning.</p> <p>The chief executive and clinical nurse managers have completed at least eight hours of training related to management of a hospital in the past year.</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</p>	<p>FA</p>	<p>The quality manager(RN) and CNMs provide cover during a temporary absence of the chief executive.</p>

<p>and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</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>	<p>FA</p>	<p>A quality and risk management programme is in place. The quality manual and the strategic, business/quality and risk management plans and procedure describe Leslie Grove's quality improvement processes. Quality goals were documented in the operations quality plan and the quality meeting minutes. The service has comprehensive policies/procedures to support service delivery. A document control policy outlines the system implemented whereby all policies and procedures are reviewed regularly. Staff are made aware of any policy changes through staff meetings, evidenced in meeting minutes.</p> <p>The monthly collating of quality and risk data includes (but not limited to) monitoring accidents and incidents, infection rates, restraint use and results of annual resident and family satisfaction surveys. Internal audits regularly monitor compliance. A corrective action form is completed where areas are identified for improvement and included evidence of implementation and sign off. Quality data is analysed for trends and is discussed at staff and management meetings, at the monthly board meeting, at handovers and displayed in the staff room (also link 1.2.4.3).</p> <p>The quality programme is linked to the annual training plan with extra and impromptu training offered as issues are identified. A quality improvement register is maintained and lists the key objectives, interventions and evaluations of the improvements listed.</p> <p>A health and safety programme is in place, with documented objectives for 2018 and regular reviews. There is an implemented risk register which includes managing identified hazards. Health and safety meetings are conducted each month. Falls prevention strategies include the analysis of falls events and the identification of interventions on a case-by-case basis to minimise future falls.</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</p>	<p>PA Low</p>	<p>The service collects all incident and accident information reported by staff on a paper-based system. Incident and accident data is collected and analysed monthly and a report documented for the monthly quality and staff meetings. Eighteen resident related incident forms were reviewed for June and July 2018. Each event involving a resident reflected a clinical assessment and follow-up by a RN, however, not all forms identified opportunities to minimise the risk of further incidents for that resident. Care staff interviewed were very knowledgeable regarding the care needs (including high falls) for all residents. Discussions with the chief executive and quality manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. A section 31 was completed on the first day of audit for a resident with an unstageable pressure injury. One</p>

of choice in an open manner.		gastrointestinal outbreak was reported to public health in appropriate timeframes.
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>The recruitment and staff selection process require that relevant checks have been completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates is kept. Ten staff files (four caregivers, four registered nurses including two CNMs, one diversional therapist and one quality manager) were reviewed and included all required documentation. Staff turnover related to care and service staff was reported as low, with some staff having been employed in excess of 20 years. Registered nurse turnover has been higher, and analysis indicates this is related to external factors.</p> <p>The service has a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Annual appraisals have been conducted for all staff whose files were sampled. A completed in-service calendar for 2017 exceeded eight hours annually. The management team and registered nurses attend external training including seminars and education sessions with the local DHB. Seven of the ten registered nurses have completed their interRAI training.</p> <p>There are seven caregivers plus three night staff who work in the dementia unit. Eight of these ten caregivers have completed the required NZQA dementia standards. Two staff have recently commenced employment and are aware of the requirement to complete the required training.</p> <p>There are 22 caregivers who work in the psychogeriatric unit. Seventeen of these 22 staff members have completed the required dementia standards. Five caregivers have not been working in the unit for six months and have commenced the enrolment process.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery, meeting contractual requirements. In addition to the chief executive (RN) who works full-time, there is a full-time quality manager (RN), two clinical nurse managers and registered nurses who are rostered on 24/7. The on-call roster is shared between the Chief executive, quality manager and two clinical nurse managers. Cleaning staff are employed over seven days a week. A diversional therapist and activities coordinator are rostered Monday to Friday with care staff supporting activities in the dementia and psychogeriatric units on weekends. Staff reported that staffing levels and the skill mix were appropriate and safe. Residents interviewed advised that they felt there are sufficient staffing.</p> <p>Leslie Groves hospital is divided into three units.</p> <p>The Redwood hospital unit has 30 hospital residents. The morning shift is covered by one acting CNM, one RN and five caregivers (two long and three short) until 3.30 pm. On the afternoon shift, one RN</p>

		<p>works from 2.30 pm till 11.00 pm and five caregivers (four long and one short shifts) cover the afternoon shift until 9.30 pm. At night, there is an RN (10.45pm – 0715) and caregiver from 8.45 pm until 7.15 am.</p> <p>The Ferntree dementia unit has 17 residents and is overseen by the CNM based in the psychogeriatric. An RN is rostered two days a week in this area. Two morning caregivers work full shifts and one a shorter shift, starts at 12 midday. Two afternoon caregivers work from 12.30 pm to 9.00 pm. There is one caregiver at night commencing at 8.45 pm until 7.15 am.</p> <p>The Taieri psychogeriatric unit with 21 current residents has a CNM rostered 7.00 am to 3.30 pm. The CNM is supported by one RN five days a week and by four caregivers (two long and two short) on morning shift. There is an RN on afternoon shift and afternoon caregivers commence at 12.30 pm with three long shifts and one short shift caregiver. At night, there is an RN (10.45pm – 0715) and caregiver from 8.45 pm until 7.15 am.</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 resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are protected from unauthorised access by being locked away in the nurses' station. Sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. Record entries are legible, dated and signed by the relevant staff member. Individual resident files demonstrate service integration. Medication charts are stored electronically.</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 are assessed prior to entry to the service by the needs assessment team, and an initial assessment was completed on admission in files sampled. The service has specific information available for residents/families/whānau at entry and it includes associated information such as the Code, advocacy, informed consent, and palliative policy and the complaints procedure. The admission agreement reviewed aligns with the ARC and ARHSS contract and 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>The transfer /discharge/exit procedures include a transfer/discharge form and the completed form is placed on file. The clinical nurse manager stated that a staff member escorts the resident if no family were available to assist with transfer, and copies of documentation are forwarded with the resident.</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>	FA	<p>Eighteen medication charts were reviewed. The facility has an electronic medication system in place. The medication management policies and procedures comply with medication legislation and guidelines. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Residents' medicines are stored securely in the medication room/cupboards. Medication administration practice complies with the medication management policy for the lunchtime medication round sighted. There was evidence of three monthly reviews by the GP. Registered nurses and caregivers administer medicines. All staff that administer medicines are competent and have received medication management training. The facility uses a robotically packed medication management system for the packaging of all tablets. The RN on duty reconciles the delivery and documents this. Temperature monitoring of the medication fridges was evidenced to be occurring as per policy. There were no residents self-administering medication on the day of audit. There are no standing orders.</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>	FA	<p>There is an external contractor providing the food services for all Leslie Grove residents. The contracted company uses a commercial kitchen at the hospital site. A dietary assessment is made by the RN as part of the assessment process and this includes likes and dislikes. There was evidence of residents receiving supplements. Fridge and freezer temperatures are monitored and recorded daily in the kitchen. Food in the fridge and freezers was covered and dated. The external contractor conducts audits as part of their food safety programme. Special or modified diets are catered for. Soft and puree dietary needs are documented in files sampled. This includes consideration of any particular dietary needs (including cultural needs). Food is transported to each unit via hot boxes. Staff record the temperature of hot and cold dishes prior to serving. Resident and families interviewed were complimentary of the food service. Additional nutritious snacks are available over 24hrs in both the dementia unit and psychogeriatric units.</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 the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The reason for declining service entry to residents to the service would be recorded on the declined entry form, and when this has occurred, the chief executive stated it would be communicated to the resident/family/whānau and the appropriate referrer. Advised residents are generally declined if they a different service type.</p>
<p>Standard 1.3.4: Assessment</p>	FA	<p>InterRAI initial assessments and assessment summaries were evident in printed format in all permanent</p>

<p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>		<p>resident files. Files reviewed across all three units identified that risk assessments have been completed on admission and reviewed six monthly as part of the evaluation. Additional assessments for management of behaviour, pain and wound care were appropriately completed according to need. For the resident files reviewed, the outcomes from assessments and risk assessments were reflected into care plans.</p>
<p>Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Low</p>	<p>The long-term care plans are comprehensive and demonstrate input from allied health in all nine files reviewed. All resident care plans sampled were resident centred; however, not all support needs were documented in detail. Short-term care plans were utilised for acute health needs in files sampled. Two PG and two psychogeriatric resident files reviewed identified current abilities, level of independence, identified needs and specific behavioural management strategies. All nine resident files included family involvement. Family members interviewed confirmed care delivery and support by staff is consistent with their expectations.</p>
<p>Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Registered nurses (RNs) and caregivers follow the care plan and report progress against the care plan each shift at handover. If external nursing or allied health advice is required, the RNs will initiate a referral (e.g., to the district nurse or wound care specialist nurse). If external medical advice is required, this will be actioned by the GPs. Staff have access to a variety of medical supplies (e.g., dressings). Continence products are available and resident files include a continence assessment and plan as part of the plan of care. Specialist continence advice is available as needed and this could be described.</p> <p>Wound assessment, plans and evaluations were fully completed for all wounds. On the day of audit, there were 10 wounds currently being managed including one unstageable pressure injury.</p> <p>Interviews with registered nurses and caregivers demonstrated an understanding of the individualised needs of residents. Monitoring charts sighted included behaviour charts, restraint monitoring forms, turning charts, food and fluid charts, regular monitoring of bowels and monthly weight management. The nurse practitioner for mental health of older person visits regularly. Strategies for the provision of a low stimulus environment could be described.</p> <p>The service has introduced the Te Ara Whakapiri end of life care pathway. The clinical nurse specialist from the Hospice has been involved in the implementation of this. This was introduced in two phases. Phase one was around education in end of life cares to all nursing and caring staff. The second phase was more around the documentation and provision of support around when to start the pathway, supporting and empowering the registered nurses to make decisions around provision of end of life cares. This has been in partnership with the GP service. There is ongoing education and working with the GP for nurses to indicate decline and initiate more conversations around end of life planning with</p>

		<p>residents and families.</p> <p>The clinical nurse specialist visits the facility twice a week and more if necessary to support the nurses and care staff on the provision of end of life cares</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 team at Leslie Groves includes two qualified diversional therapists and one activities coordinator who provide activities from 9.30 am - 3.30 pm in the hospital unit, 10.00 am – 4.00 pm in the dementia unit and 11.00 am – 6.00 pm in the psychogeriatric unit. The activities team including the activities coordinator from Leslie Groves rest home meet on a regular basis.</p> <p>The activity programme is planned monthly. Activities planned for the day are displayed on noticeboards around the dementia, psychogeriatric and hospital areas. An activity assessment and plan are developed for each individual resident based on assessed needs and individual abilities. Activity plans were reviewed six monthly in files sampled. Activity progress notes are maintained. Residents are encouraged to join in activities that are appropriate and meaningful and are encouraged to participate in community activities. Community groups are invited to participate in the programme. One-on-one time is provided for residents who are not able or choose not to join group activities. The group activities cover physical, cognitive, social and spiritual needs. There are regular visiting entertainers and community group. There is a weekly church service and some residents attend church services in the community. Residents can go on outings using the service's van which is shared between the two facilities.</p> <p>Resident meetings provide a forum for feedback relating to activities in the hospital unit. Feedback is received through discussions and conversations with relatives in the dementia and psychogeriatric unit. Residents and family members interviewed discussed enjoyment in the programme and the diversity offered to all residents. Caregivers were observed at various times throughout the day diverting residents from behaviours.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Care plans reviewed had been evaluated by registered nurses six monthly, or when changes to care occurs. Written evaluations reviewed described the resident's progress against the residents identified goals. Short-term care plans for short-term needs are evaluated and either resolved or added to the long-term care plan as an ongoing need. The three-monthly multidisciplinary review involves the RN, GP, and resident/family mental health nurse practitioner and a palliative care specialist nurse attends if required. The family are notified of the outcome of the review by phone call and if unable to attend. The family members interviewed confirmed they are invited to attend the multidisciplinary care plan reviews and GP visits.</p>

<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 is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where a resident's condition had changed, and the resident was reassessed for a higher or different level of care. Discussion with the clinical manager and registered nurses identified that the service has access to a wide range of support either through the GP or DHB.</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>All chemicals are labelled with manufacturer labels. Safety data charts were available, and the hazard register identifies hazardous substances. Safe chemical handling training has been provided. There are designated areas for storage of cleaning/laundry chemicals and chemicals were stored securely. Laundry and sluice rooms are locked when not in use as observed during a tour of the facility. Gloves, aprons, and goggles are available for staff.</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>Leslie Groves hospital has a current building warrant of fitness. Hot water temperatures are checked monthly. Medical equipment and electrical appliances have been tested and calibrated. Regular and reactive maintenance occurs. Residents were observed to mobilise safely within the facilities. There are sufficient seating areas throughout the facility. The exterior has been well maintained with safe paving, outdoor shaded seating, lawn and gardens. There is a safe outside area that is easy to access. There are secure garden areas off the dementia and psychogeriatric units. Caregivers interviewed confirmed there was adequate equipment to carry out the cares according to the resident needs as identified in the care plans. The dementia unit has several areas designed so that space and seating arrangements provide for individual and group activities. There are quiet, low stimulus areas that provide privacy when required including individual rooms.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p>	FA	<p>All resident rooms are single rooms with individual or shared ensuites. There are sufficient numbers of resident communal toilets in close proximity to resident rooms and communal areas. Residents interviewed stated their privacy and dignity is maintained while attending to their personal cares and</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.		hygiene. The communal toilets are well signed and identifiable and include vacant/in-use signs. Visitor toilet facilities are available.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	The resident rooms are of sufficient size to meet the resident's assessed needs. Residents are able to manoeuvre mobility aids around the bed and personal space. All beds are of an appropriate height for the residents. Caregivers interviewed reported that rooms have sufficient space to allow cares to take place. The resident rooms were personalised.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	In the hospital, dementia and psychogeriatric units there are several lounge areas and dining room areas which are easily accessible for the residents. The dining rooms are spacious and located directly off the kitchen/servery areas. The furnishings and seating are appropriate for all resident's needs. Residents interviewed reported they are able to move around the facility and staff assisted them when required. Activities take place in any of the lounges. The dementia and psychogeriatric units provide adequate space to allow maximum freedom of movement while promoting safety for those that wander, including dining and lounge areas.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	The service has monitored the effectiveness and compliance of cleaning and laundry policies and procedures. There is a separate laundry area at the hospital site where all linen and personal clothing is laundered. Manufacturer's data safety charts are visible. All chemicals were stored securely. Residents and family interviewed reported satisfaction with the laundry service and cleanliness of the room/facility.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an	FA	A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Six monthly fire evacuation practice documentation was sighted. A contracted service provides checking of all facility equipment including fire equipment. Fire training and security situations

<p>appropriate and timely response during emergency and security situations.</p>		<p>are part of orientation of new staff and include competency assessments. Emergency equipment is available at the facility. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas cooking. Short-term backup power for emergency lighting is in place.</p> <p>There is a staff member on each duty that have completed first aid training. There are call bells in the residents' rooms, and lounge/dining room areas. Residents' rooms were observed to have their call bells in close proximity.</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>	<p>FA</p>	<p>All communal and resident bedrooms have external windows with plenty of natural sunlight. General living areas and resident rooms are appropriately heated with radiators and well ventilated. Residents and family interviewed, stated the environment was warm and comfortable.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>Leslie Groves has an established infection control (IC) programme. The infection control programme is appropriate for the size, complexity and degree of risk associated with the service. The quality manager (a registered nurse) is the designated infection control nurse with support from the clinical nurse specialist and registered nurses. Infection control matters are discussed at registered nurse meetings. Regular audits have been conducted and education has been provided for staff. The infection control programme has been reviewed annually.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>There are adequate resources to implement the infection control programme at Leslie Groves. The infection control (IC) coordinator has maintained her practice by attending regular updates. External resources and support are available when required. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facilities and alcohol hand gel is freely available throughout the facility.</p>

<p>Standard 3.3: Policies and procedures</p> <p>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.</p>	<p>FA</p>	<p>The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes roles, responsibilities, procedures, the infection control team and training and education of staff. The policies are reviewed and updated at least two yearly.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The service is committed to the ongoing education of staff and residents. Education is facilitated by the infection control coordinator with support from the registered nurses. All infection control training has been documented and a record of attendance has been maintained. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak had been resolved. Information was provided to residents and visitors that are appropriate to their needs and this was documented in medical records. Education around outbreak management and infection prevention and control has been provided in 2017 and 2018.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Infection surveillance and monitoring is an integral part of the infection control programme and is described in policy. The quality manager is the designated infection control nurse. Monthly infection data is collected for all infections based on signs and symptoms of infection. Surveillance of all infections is entered onto a monthly resident infection data sheet. The data has been monitored and evaluated monthly and annually at facility and organisational level. An outbreak in July 2017 in the psychogeriatric unit was well managed.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively</p>	<p>FA</p>	<p>The service is committed to restraint minimisation and safe practice was evidenced in the restraint policy and interviews with clinical staff. Policies also include managing resident's challenging behaviours, alternatives to restraint and guidance for staff in responding to challenging behaviours and residents' needs. The service endeavours to provide a restraint-free environment. Restraint minimisation is overseen by a restraint coordinator who is the clinical nurse specialist. There are six residents</p>

minimised.		documented as using enablers. Consents have been completed by the competent resident or relative. A full assessment is completed prior to implementing the enablers and monitoring is documented in progress notes.
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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 1.2.4.3</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>	PA Low	Caregivers and registered nurses report that when an incident occurs the staff member who discovers the incident completes an incident form. This is then provided to the registered nurse during the same shift (usually immediately) for follow-up. All 18 incident forms sampled documented immediate follow up and assessment by a registered nurse.	Eight of 18 incident forms sampled did not have documented evidence of opportunities to improve service delivery and to identify and manage the risk.	<p>Ensure that all incidents are reviewed to identify opportunities to minimise future occurrences.</p> <p>90 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired</p>	PA Low	Interventions in the care plans are detailed and individualised to resident need and indicate the level of support required. However, weight loss is not always identified, therefore interventions are not activated in a	There were insufficient interventions around management of unintentional weight loss for two hospital	Ensure weight loss is monitored, and interventions are initiated as

outcomes identified by the ongoing assessment process.		timely manner.	level and two PG residents.	soon as weight loss is identified. 60 days
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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.