

Leighton House Limited

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Leighton House Limited
Premises audited:	Leighton House
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 4 June 2019 End date: 5 June 2019
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:	45

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

Leighton House is operated by Dementia Care New Zealand. The service provides care for up to 50 residents requiring rest home or hospital (medical and geriatric) level care. On the day of the audit, there were 45 residents.

This surveillance audit was conducted against the health and disability sector standards and the district health board contract. The audit process included the review of policies and procedures, the review of resident and staff files, observations and interviews with residents, family members, staff and management.

The service is managed by an experienced operations manager who has been in the role since 2013 and a clinical manager (registered nurse), who commenced the role in December 2018.

The organisation has a wide range of support available including: a clinical advisor, national clinical manager, quality system manager, company educator and mental health nurse, operational management leader and owners/directors.

Residents, relatives and the nurse practitioner (NP) interviewed, spoke positively about the service provided.

This audit has identified areas for improvement around assessments, service provision timeframes, wound management and monitoring forms and aspects of medications management.

The service has maintained a continuous improvement around quality and activities.

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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Communication with residents and family was evidenced in care plans and confirmed on interviews. Complaints processes are implemented, and complaints, and concerns are actively managed.

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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There is a business plan with goals for the service that has been regularly reviewed. A clinical manager and operations manager are responsible for day-to-day operations. The quality system has been implemented. Quality data is collated for accident/incidents, infection control, internal audits, concerns and complaints and surveys. Incidents are appropriately managed. Corrective actions are implemented and evaluated where opportunities for improvements are identified.

There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation and training programme that provides staff with relevant information for safe work practices. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care. Services are planned and coordinated and are appropriate to the needs of the residents. Registered nursing cover is provided 24 hours a day, 7 days a week.

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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Entry to the service is managed primarily by the clinical manager or registered nurses. There is comprehensive service information available. Initial assessments are completed by a registered nurse. Care plans are based on the interRAI outcomes and other assessments and are written by the registered nurses in a way that enables all staff to clearly follow their instructions. Residents and family interviewed confirmed they were involved in the care planning and review process. The documented activities programme is varied and interesting. Staff have had education around medication management and all staff who administer medications have completed a competency assessment. General practitioners review residents at least three monthly or more frequently if needed. Meals are prepared on site. The menu is varied and appropriate. Individual and special dietary needs are catered for. Alternative options are able to be provided. Residents interviewed were complimentary about the food service.

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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The building has a current warrant of fitness. The environment is warm and comfortable. There is adequate room for residents to move freely about the home using mobility aids. Communal areas are well utilised for group and individual activity. There is adequate equipment for the safe delivery of care. All equipment is well maintained and on a planned schedule.

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. Staff receive regular education and training on restraint minimisation. The service had no enablers in use and one restraint.

Infection prevention and control

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

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	1	12	0	2	1	0	0
Criteria	2	35	0	2	2	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The organisational complaints policy is being implemented at Leighton House. The operations manager has overall responsibility for ensuring all complaints (verbal or written) are fully documented and investigated. The clinical manager and national clinical manager are involved in clinical complaints. The facility has an electronic up-to-date complaint register. Concerns and complaints are discussed at relevant meetings. There have been eight complaints made in 2018 and two complaints received in 2019 year to date. There was documented evidence of internal investigations and family meetings with resolution for all complaints. Complaints have been acknowledged and addressed within the required timeframes. Management operate an open-door policy.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	FA	<p>There is an incident reporting policy and reporting forms that guide staff to their responsibility to notify family of any resident accident/incident that occurs. Twelve incident forms reviewed evidenced the family had been informed of the accident/incident. Three relatives (two rest home and one hospital) interviewed, stated that they are informed when their family members health status changes. Monthly resident meetings occur. A family focus meeting occurs annually and provides relatives with an opportunity to feedback on the service as confirmed by three family members (two hospital and one rest home) interviewed. Relatives receive newsletters to keep them informed on facility matters, activities and topics of interest. Five residents (four rest home and one hospital) interviewed, stated that they were welcomed on entry and were given time and explanation about the services and procedures. Non-</p>

<p>conducive to effective communication.</p>		<p>subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. Interpreter policy and contact details of interpreters is available.</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>Leighton House is a Dementia Care New Zealand (DCNZ) facility situated in Gisborne. The service provides care for up to 50 residents requiring hospital, (medical and geriatric) and rest home level care. On the day of the audit there were 45 residents (14 at hospital level care and 31 at rest home level care). All residents were under the aged care contract. There are currently 25 dual-purpose beds. There is a strong focus within the organisation to promote independence, to value the lives of residents and staff and this is supported by the vision and values statement of the organisation. DCNZ has an overall 2018 – 2019 business/strategic plan based on “our services”, “our people”, “our environment” and the “sharing of experiences”. The business plan is regularly reviewed. The organisation has a philosophy of care, which includes a mission statement.</p> <p>The clinical manager/registered nurse has been in the role since December 2018 and is supported by the national clinical manager. The operations manager (non-clinical) of Leighton House has been in the role since August 2013. The operations manager reports to the operational management leader at head office. The operational manager is supported by an organisational quality systems manager, education coordinator and mental health nurse, clinical director and owners/directors at head office. The operations manager attends DCNZ seminars and has completed more than eight hours training related to managing a rest home and hospital in the past year.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>There is a quality plan that includes quality goals and risk management plans for Leighton House. The quality programme is managed by the operations manager and clinical manager. A quality systems manager for the organisation oversees the quality programme, ensuring all aspects of quality management is implemented.</p> <p>Interviews with staff confirmed that there is discussion about quality data at various facility meetings including monthly quality improvement meetings and clinical meetings. There is documented evidence in meeting minutes of quality data, trends and analysis. Minutes and the monthly quality bulletin (displayed on the staff noticeboard) contain topical information and quality data. Organisational policies meet all current requirements and are reviewed at head office. Staff have access to the policy manuals.</p> <p>Data is collected in relation to a variety of quality activities and an internal audit schedule has been completed. The operations manager completes environmental and non-clinical audits. The clinical manager undertakes all clinical audits. The internal audit programme continues to be implemented and all issues identified had corrective action plans and resolutions. The quality systems manager completes compliance site audits three monthly. Benchmarking reports are generated throughout the year and an annual review of the data is completed. An electronic quality improvement database is maintained and document improvements and actions.</p> <p>Annual resident surveys for 2019 have been completed with positive results overall. Results were published in the</p>

		<p>family newsletter and discussed at resident meetings. Quality improvements raised and implemented were related to maintenance staff availability and wheelchair availability.</p> <p>The service has a Health and Safety Committee which comprises of health and safety representatives, falls coordinator, restraint coordinator and care staff. All committee members have completed external health and safety education. Health and safety objectives for 2019 are known by staff and include a reduction of staff sprain/strain accidents.</p> <p>Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. A falls coordinator is responsible for correlating falls and presenting to the resident events analysis and quality meetings.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>There is an incident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Individual incident reports are completed manually and entered electronically for each incident/accident with immediate action noted and any follow-up action required. A review of 12 incident/accident forms from across all areas of the service, identified they all are fully completed, including follow-up by a RN and relative notification. Post-falls assessments included neurological observations for any unwitnessed falls. The clinical manager is involved in the adverse event process, with links to the applicable meetings (quality, health and safety, staff, resident events analysis meetings). This provides the opportunity to review any incidents as they occur. The operational manager was able to identify situations that would be reported to statutory authorities. There has been a section 31 for a small electronic fire and a notification to public health for a norovirus outbreak in November 2018.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment</p>	FA	<p>There are human resources management policies in place. This includes that the recruitment and staff selection process require that relevant checks are completed to validate the individual's qualifications, experience and veracity. Current practising certificates were sighted. Six staff files were reviewed (one clinical manager, one registered nurse, two healthcare assistants, one activities coordinator and one cook) and there was evidence that reference checks and police vetting were completed before employment. Annual staff appraisals were evident in all staff files reviewed for those who have been with the service over twelve months.</p> <p>The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. Completed orientation was evidenced and staff described the orientation programme. The service uses the "Best Friends" approach to caring for residents, and staff complete an in-service education</p>

<p>practice and meet the requirements of legislation.</p>		<p>programme on this approach to care. The in-service education programme for 2018 has been completed and the plan for 2019 is being implemented. The service maintains a comprehensive staff competency database which evidences staff completion within required timeframes. The clinical manager and registered nurses are able to attend external training, including sessions provided by the local DHB. The clinical managers within the organisation attend annual DCNZ National Forums in advanced nursing practice, competency driven (total of 40 hours annually). Eight hours of staff development or in-service education has been provided annually. All staff (except three new staff) have completed first aid training. Three registered nurses including the clinical manager are interRAI trained.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>DCNZ organisational policy outlines on call requirements, skill mix, staffing ratios and rostering for facilities. The operations manager and clinical manager work full time Monday to Friday and are on call 24/7. Interviews with four healthcare assistants stated the RNs are supportive and approachable. In addition, they reported overall there are sufficient staff on duty and staff leave is always covered. Interviews with residents and relatives indicated overall there are sufficient staff to meet resident needs.</p> <p>Staffing at Leighton House is rostered as one unit (14 hospital and 31 rest home residents). There is a registered nurse on duty on each shift, seven days per week. There are six healthcare assistants (four full and two short-shifts) on morning shift, six healthcare assistants (four full and two short-shifts) on afternoons and two healthcare assistants on night shift.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>Medi-map electronic medication charting is utilised for prescribing and administering medications. Ten medication charts were reviewed and included six hospital and four rest home residents. The medication management policies and procedures comply with medication legislation and guidelines. Not all medicines are appropriately stored in accordance with relevant guidelines and legislation. Medication administration practices did not comply with the medication management policy on the medication round observed. Medication prescribed is signed as administered using medi-map. Registered nurses and senior healthcare assistants 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 registered nurse on duty reconciles the delivery and documents this. There was evidence of three-monthly medication reviews by the GP. All medication charts on medi-map have photo identification. Allergies or nil known allergies were recorded. One resident self-administering their own medicines fully complied with the organisations requirements for residents who are self-medicating.</p>
<p>Standard 1.3.13:</p>	<p>FA</p>	<p>The service employs a qualified chef and all food is cooked on site. There is a verified food control plan in place. A</p>

<p>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>resident nutritional profile is developed for each resident on admission and this is provided to the kitchen staff. This document is reviewed at least six monthly as part of the care plan review. The kitchen is able to meet the needs of residents who require special diets and the cook works closely with the registered nurses on duty. The kitchen staff have completed food safety training. The chef and cooks follow a rotating seasonal menu, which was reviewed in June 2017 by a dietitian. The temperatures of refrigerators, freezers and cooked foods are monitored and recorded. There is special equipment available for residents if required. All food is stored appropriately. Residents and the family members interviewed were very happy with the quality and variety of food served.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Low</p>	<p>Registered nurses (RNs) and healthcare assistants 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 (eg, to the district nurse or wound care specialist nurse). If external medical advice is required, this is actioned by the GPs or nurse practitioner. Staff have access to medical supplies (eg, dressings). Continence products are available and resident files include a continence assessment and plan as part of the plan of care.</p> <p>Wound assessments and short-term care plans were in place for twenty-one wounds (one surgical wound, twelve skin tears, three corns, two moisture lesions, one lesion, one cellulitis and one skin abrasion). Wound assessments, plans and evaluations are in place for all wounds, however not all are fully documented. The RNs have access to specialist nursing wound care management advice if required. A corrective action plan has been implemented following an increase in skin tears and a manual handling update has been provided to staff.</p> <p>Monitoring charts are evident for nutritional intake, weight, bowel movements and analgesia effectiveness, however not all are fully documented.</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</p>	<p>CI</p>	<p>The service employs a diversional therapist and two additional activities staff (both undertaking diversional therapy training) totalling seventy hours per week over seven days. The activity programme is planned around meaningful everyday activities and special events (a calendar template is provided by head office). There is a range of activities both within and external to the facility, one-to-one and group activities and numerous groups coming to the facility from the community.</p> <p>There is evidence that the residents have input into review of the programme by one-to-one feedback, the resident's monthly meeting, a survey specific to activities and the resident survey, and this feedback is considered in the development of the residents' activity programme. The activity programme is developed monthly. A copy of the activity plan is displayed on the noticeboard. The staff also remind residents of the activities that are occurring daily.</p> <p>The service has a van which can accommodate mobility aids. Outings occur weekly to cafés and residents reported</p>

<p>service.</p>		<p>visiting other aged care facilities to join in activities once a week.</p> <p>An activity profile is completed on admission in consultation with the resident/family (as appropriate). The activities documentation in the resident files sampled reflected the specific requirements of each resident. Residents interviewed evidenced that the activity programme had a focus on maintaining independence and providing meaningful activities.</p> <p>In the files reviewed the activities plans had been reviewed six-monthly. Progress notes evidenced frequent updates by activities staff.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The registered nurses evaluate all initial care plans, however not all files reviewed had been completed within three weeks of admission (link 1.3.3.3). Files sampled demonstrated that the long-term care plan was evaluated. However, in files reviewed this did not always happen at least six-monthly or earlier if there was a change in health status (link 1.3.3.3). There was at least a three-monthly review by the GP or nurse practitioner. All changes in health status were documented and followed up. Re-assessments have been completed using the interRAI assessment tool for all residents who have had a significant change in health status. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files sampled. Where progress is different from expected, the service responds by initiating changes to the care plan.</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>	<p>FA</p>	<p>Leighton House has a current building warrant of fitness that expires on 28 February 2020. The facility is divided into five wings: Admin, North, East, River and Garden. There are currently 25 dual-purpose beds. All rooms are large enough for mobility equipment. The corridors allow for the use of mobility equipment. Residents have adequate internal space to meet their needs. External areas are safe and well maintained. The facility has a van available for transportation of residents.</p> <p>Maintenance requests are logged into a maintenance book kept in the nurses' station and signed off when completed. External contractors carry out larger repairs and they are available 24/7 for essential services. Planned maintenance occurs as scheduled. Electrical equipment has been tested and tagged and clinical equipment has been serviced/calibrated annually.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried</p>	<p>FA</p>	<p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control officer uses the information obtained through surveillance to determine infection control activities, resources and education needs. Internal infection control audits also assist the service in evaluating infection control needs. There is liaison with the GP and laboratory staff that advise and provide feedback/information to the</p>

<p>out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>service. The GP and the service monitor the use of antibiotics. Infection control data is collated monthly and reported at the various facility meetings. Individual resident infection control summaries are maintained. All infections are documented on the infection monthly online register. The surveillance of infection data assists in evaluating compliance with infection control practices.</p> <p>The service had a gastrointestinal outbreak in November 2018. The outbreak was appropriately managed with evidence of additional staff education, a full staff debrief meeting and appropriate notifications made.</p> <p>At the time of audit, a number of residents were unwell with respiratory symptoms. An outbreak was declared on the day of audit. Policy and procedures were implemented, and management staff were aware of the need to make appropriate notifications. The national clinical manager was advised.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>There is a restraint policy in place that states the organisations philosophy to restraint minimisation. There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. Currently the service has one resident requiring the use of restraint (tray table) and no residents using enablers.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA Moderate</p>	<p>The registered nurses in the hospital and senior healthcare assistants are responsible for the safe administration of medication. On the medication rounds observed at lunchtime the registered nurse did not follow the correct medication administration process. All medication charts reviewed had allergies or nil known allergies documented.</p>	<p>i) One staff was observed administering medications with five individual robotic packs and pre-poured liquids on top of the trolley during a medication round.</p> <p>ii) Two eyedrops in the medication trolley had not been discarded after being opened for 30 days as per</p>	<p>i) Ensure that staff who administer medication follow acceptable medication administration practices, and guidelines.</p> <p>ii) Ensure eyedrops are discarded as per manufacturer's instructions.</p>

			manufacturer's instructions.	30 days
<p>Criterion 1.3.12.6</p> <p>Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.</p>	PA Low	Medication charts reviewed identified that controlled drugs were appropriately prescribed. Signing records and the controlled medication register documented two staff always sign for medication. Weekly checks of the controlled drug register have not occurred as scheduled.	The controlled medication register had not been stock-checked weekly.	<p>Ensure that the controlled medication register has a documented weekly stock check</p> <p>30 days</p>
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	PA Low	Registered nurses complete initial care assessments and care plans within 48 hours of admission. InterRAI assessments, long-term care plans and care plan evaluations are completed, however, are not always completed within required timeframes. The service has recently experienced a high RN turnover which has impacted on the services ability to meet contractual timeframes. All interRAI assessments were current on the day of audit.	<p>(i) One of five resident (rest home) reviewed did not have an interRAI assessment completed within 21 days of admission.</p> <p>(ii) Three of five resident files (two hospital and one rest home) reviewed did not evidence interRAI assessments had been reviewed six monthly</p> <p>(iii) Three of five (two hospital and one rest home) long terms care plans had not been reviewed six</p>	<p>(i)-(ii) Ensure interRAI assessments are completed within 21 days of admission and reviewed six monthly.</p> <p>(iii) Ensure long-term care plans are reviewed six monthly.</p> <p>90 days</p>

			monthly.	
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Moderate</p>	<p>All identified wounds had a wound plan in place, but not all were individually documented or reflected the wound or care interventions documented. Staff were evidenced to be caring and attentive to residents with resident and family member agreeing that caregivers were kind and caring. Monitoring of effectiveness of 'as required' analgesia was not always documented.</p>	<p>(i) Effectiveness of 'as required' analgesia was not documented for one hospital resident.</p> <p>(ii) Wound assessments were not fully documented for six current wounds including two pressure injuries.</p> <p>(iii) Wound management plans were not fully documented for three current wounds.</p> <p>(iv) One wound assessment and management plan was documented for a resident with two separate wounds.</p>	<p>(i) Ensure effectiveness of analgesia is documented.</p> <p>(ii)-(iii) Ensure wound assessments and management plans are fully documented.</p> <p>(iv) Ensure all wounds are individually documented.</p> <p>60 days</p>

Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	CI	Quality improvement forms are utilised at Leighton House and document actions that have improved outcomes or efficiencies in the facility. The service continues to collect data to support the implementation of corrective action plans. The service is proactive in developing and implementing quality initiatives. All meetings include feedback on quality data where opportunities for improvement are identified.	Leighton House continues to actively analyse data collected monthly, around accidents and incidents, infection control, restraint etc. The results of quality data analysis and identified trends and issues are communicated to staff at handover, staff meetings and in the monthly quality bulletin. Any identified common themes around incidents/infections etc results in further education and updates at handovers between shifts and meetings. Documentation reviewed identified that strategies are regularly evaluated. Leighton House is continuing to focus on quality improvements including a reduction in urinary tract infections and resident falls. Analysis to date confirms strategies implemented are meeting objectives.
Criterion 1.3.7.1 Activities are planned and	CI	All residents are assessed at admission and in an ongoing manner, to establish interests and skills. A plan is developed for the residents around activities. The	Following audit results in 2016, the service implemented a number of positive changes. Activities are now provided seven days per week. Regular ongoing activities surveys provide feedback on all aspects of the programme along with suggestion for additional activities. Residents are

<p>provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>		<p>activity programme has been reviewed and improved with resident input, resulting in significantly higher attendance at activities.</p>	<p>encouraged to make suggestions and provide feedback on activities at monthly resident meetings. Resident feedback determines the continuation of activities.</p> <p>Activities include a children's activities day, music activities, gardening groups growing their own vegetables, which are cooked and eaten by residents, weekly cooking clubs, spontaneous activities, BBQs, pet therapy, art therapy, poetry and drama and movies. On the days of audit, residents and visitors were observed joining in activities and the musical entertainment. During the week and at weekends, the Leighton House van transports residents to events happening in the local community.</p> <p>Residents and family members interviewed reported enjoying the variety and diversity of the programme and the ability to attend activities of interest. Resident meeting minutes sighted continue to evidence a high attendance at 2019 activities.</p>
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End of the report.