

Leslie Groves Society of St John's (Roslyn) - Leslie Groves Hospital

Introduction

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

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

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

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

The specifics of this audit included:

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| Legal entity: | Leslie Groves Society of St John's (Roslyn) |
| 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: 14 January 2020 End date: 15 January 2020 |
| 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: | 66 |

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 |
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|  | 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 |
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| 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 Hospital is owned and governed by Leslie Groves Society of St Johns (Roslyn). The facility provides care for up to 71 residents requiring hospital, dementia and psychogeriatric care. On the day of the audit there were 66 residents.

This unannounced surveillance audit was conducted against a subset of 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, relatives, staff, the GP and management.

The facility is currently being managed by the chairman of the board acting as the facility manager and is supported by a clinical manager (registered nurse), unit nurse managers, a team of nurses and healthcare assistants.

The previous audit identified shortfalls around incident reporting and weight management which have been addressed.

This audit has identified shortfalls around communication, aspects of quality, orientation, education, monitoring charts, medication room temperatures, building warrant of fitness, equipment and hot water monitoring and restraint.

Consumer rights

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| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. | | Some standards applicable to this service partially attained and of low risk. |
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A policy on open disclosure is in place. There is evidence that residents and relatives are kept informed. The rights of the resident and/or their relatives to make a complaint is understood, respected and upheld by the service. A policy around complaints management is in place.

Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. | | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |
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Services are planned, coordinated and are appropriate to the needs of the residents. Quality data is collated monthly, quality initiatives are planned, meetings are held regularly with staff and residents. A health and safety committee is in place.

Residents receive appropriate services from suitably qualified staff. Human resources policies are in place. A role-specific orientation programme is in place for new staff. An education and training plan is in place and includes in-service education and

competency assessments. Registered nursing cover is provided twenty-four hours a day, seven days a week. Residents, relatives and staff reported that staffing levels are adequate to meet the needs of the residents.

Continuum of service delivery

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| <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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The registered nurses complete interRAI assessments, risk assessments, care plans and evaluations within the required timeframes. Care plans are individually developed with the resident, and family/whānau involvement is included where appropriate. Care plans are 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. Care plans demonstrate service integration. Care plans were updated for changes in health status. Resident and family interviewed confirmed they were involved in the care plan process and review. The general practitioner/nurse practitioner completes an admission assessment and reviews the residents at least three-monthly.

Activities are provided that are meaningful and ensure that the resident maintains involvement in the community. There were 24-hour activity plans for residents in the dementia care and psychogeriatric care units that were individualised for their needs.

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/NP 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. Nutritional snacks are available 24-hours for residents in the dementia and psychogeriatric care units. The menu

is designed by a dietitian with summer and winter menus. Dietary requirements are provided where special needs are required. Residents interviewed responded favourably to the food provided.

Safe and appropriate environment

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| 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. | | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |
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The building warrant of fitness expired in March 2019. There is a preventative and planned maintenance schedule in place.

Restraint minimisation and safe practice

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. | | Some standards applicable to this service partially attained and of low risk. |
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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 was one resident documented as using an enabler. Staff are trained in restraint minimisation, challenging behaviour and de-escalation.

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.

Leslie Groves Hospital continues to implement their infection surveillance programme. Infection control issues are discussed at the management/quality meetings. The infection control programme is linked with the quality programme. An outbreak in December 2019 was well managed.

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) |
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| Standards | 0 | 9 | 0 | 6 | 2 | 0 | 0 |
| Criteria | 0 | 31 | 0 | 9 | 3 | 0 | 0 |

| Attainment Rating | Unattained Negligible Risk (UA Negligible) | Unattained Low Risk (UA Low) | Unattained Moderate Risk (UA Moderate) | Unattained High Risk (UA High) | Unattained Critical Risk (UA Critical) |
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| 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 |
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| <p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p> | PA Low | <p>Complaints forms are available at the entrance to the facility. Information around the complaints process is provided on admission. A record of all complaints, both verbal and written was maintained for 2018 on a complaints register; however, the register was not completed for 2019, there is one in place for 2020. There were fourteen complaints received in 2018, seven were care related. All were acknowledged within timeframes, investigations, meetings with families and discussions with staff were all available on file. All complaints were signed by the manager as closed.</p> <p>There were two complaints recorded for 2019, which were not acknowledged within expected timeframes.</p> <p>Compliments, complaints and any required follow-up is discussed at the combined management/quality meetings as sighted in the minutes, however not always discussed at the unit meetings (link 1.2.3.6). Residents and relatives advised that they are aware of the complaints procedure and how to access forms.</p> <p>The previous HDC complaints from April 2017, November 2018, and May 2019 have been closed off with all actions completed.</p> |
| <p>Standard 1.1.9: Communication</p> <p>Service providers</p> | PA Low | <p>Comprehensive information is provided at entry to residents and family/whānau. Five hospital level residents interviewed stated that they were welcomed on entry and were given time and explanation about the services and procedures. The acting facility manager, clinical manager, and the three-unit managers were available to residents and relatives and they promote an open-door policy. Five relatives (three hospital, one dementia and one</p> |

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| <p>communicate effectively with consumers and provide an environment conducive to effective communication.</p> | | <p>psychogeriatric) interviewed, advised that they felt they were well informed when residents' health status changes, however, the electronic adverse event forms reviewed in January 2020 and December 2019 evidenced that not all relatives had been informed following incidents. Four registered nurses and one enrolled nurse, five healthcare assistants, the occupational therapist, activities assistant, and the maintenance person interviewed fluently described instances where relatives would be notified. Interpreter services are available of required.</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 Society of St John's Parish (Roslyn). 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 66 residents in total. Thirty residents in the 31-bed hospital unit, 15 residents in the 17-bed dementia unit, and 21 residents in the 23-bed psychogeriatric unit.</p> <p>The service is currently managed by a temporary manager (Chairman of the Board) until the position of facility manager is filled (vacant since the 23 December 2019). The temporary manager has a background in education and property management with affiliations with another Anglican run facility. He has been on the board of Trustees for six years. From September to December 2018 he acted in the manager role prior to appointing the previous manager. The acting manager has attended a governance seminar around not for profit organisations and is booked in to attend the NZACA workshop for managers and aspiring leaders. The MOH and DHB have been notified of all changes in management.</p> <p>The clinical manager (registered nurse) has been in the role since October 2018. She has experience in age care and has previously been the quality manager for Leslie Groves and the manager of the Leslie Groves rest home facility. Both managers' report monthly to the board (or more frequently). The clinical manager has attended NZACA seminar, attended the wound care conference, has a current first aid instructor certificate and attended sessions on performance appraisals and the disciplinary process.</p> <p>The temporary manager is responsible for non-clinical day to day running of operations. The clinical manager is responsible for clinical aspects and oversight of the unit managers and staff and oversees the rest home facility.</p> <p>The 2019 strategic plan and the operation/quality plan had not been documented (link 1.2.3.1), the 2020 plan is in the development process. Proposed goals include (but not limited to) appointment a facility manager, continue with environmental projects such as continuing to develop paths throughout the grounds, developing a more suitable and individualised activities programme, continue to upskill and develop new staff and continue with recognising long service staff.</p> |
| <p>Standard 1.2.3: Quality And Risk</p> | <p>PA</p> | <p>There has been no documented strategic plan or quality and risk plan in place since 2018. The service has recently</p> |

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| <p>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>Moderate</p> | <p>adopted an electronic system which includes quality and resident management.</p> <p>Quality initiatives have been occurring, such as departments having their own budgets, the unit managers managing their unit including rostering, the appointment of an occupational therapist to assist with the activities programme, the change in title to healthcare assistants instead of caregivers, allied health professionals such as the dietitian visiting on a regular basis, the appointment of an external housekeeping company, and hosting education sessions at Leslie Groves for other residential facilities to join has been initiated, however these are not documented or reviewed in a formal manner.</p> <p>Collation of quality data including infections, and adverse events are reviewed monthly, reported to the management/quality meeting, and analysed three monthly for trending. Benchmarking is available in the electronic system; this is planned to be utilised once the system is fully embedded. Monthly internal audits have been completed for medications and hot water temperatures, however there have been no other internal audits completed around resident files, HR or environment. Hot water temperatures were not documented for December (link 1.4.2.1). Corrective actions identified have been completed and signed off. Quality data collated has been discussed at the combined management and quality meetings as sighted in the minutes, however these are not always discussed at the unit meetings. Staff interviewed were unable to describe the trending or corrective actions required. Minutes of the meetings and memos are available in the staff room for staff to read.</p> <p>A meeting schedule is in place and meetings have been held according to the schedule, however not all information around quality data is discussed at the individual unit meetings. Resident meetings are held three monthly in the Redwood (hospital) unit. Residents in the Redwood meetings use the opportunity to provide feedback through the meetings. A new initiative was started to hold resident and relative meetings in the dementia units, this had only occurred once so far. The relatives from the dementia units stated they felt the meeting held was informative and they had the opportunity to provide feedback.</p> <p>There was no resident survey completed in 2019 as per the ARC agreement.</p> <p>Leslie Groves has appointed a health and safety contractor (due to commence work) to assist with reviewing policies, updating the hazard register and the health and safety programme. There is a risk register which includes managing identified hazards, however the hazard register has not been reviewed in the last year. Health and safety meetings are conducted each month. All health and safety representatives on the committee have completed level 2 health and safety online training.</p> <p>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</p> | <p>FA</p> | <p>The service collects all information around adverse events on the electronic system. Adverse event data is collected monthly and analysed three monthly. A report is documented for the monthly combined management/quality meetings; however, this is not consistently discussed at the unit meetings (link 1.2.3.6). Ten</p> |

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| <p>Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p> | | <p>(three dementia, three hospital and four psychogeriatric) resident electronic adverse event forms were reviewed for December 2019 and January 2020. Each event involving a resident reflected a clinical assessment and follow-up by a RN; however, did not always document relative notification (link 1.1.9.1). All adverse event forms identified opportunities to minimise the risk of further incidents for that resident, the previous finding has been addressed.</p> <p>Healthcare assistants interviewed were very knowledgeable regarding the care needs (including high falls) for all residents. Discussions with the management confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Section 31 forms were sighted for three pressure injuries, RN availability and a sudden death. The coroner was informed of the sudden unexpected death, Leslie Groves is awaiting feedback.</p> |
| <p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p> | <p>PA Low</p> | <p>The recruitment and staff selection process requires that relevant checks have been completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates is kept. Six staff files; the clinical manager, one-unit manager, one registered nurse, the occupational therapist, and two HCA (one long standing, and one recently employed) were reviewed. All files had an agreement and job description, however not all files reviewed had current appraisals or role-specific orientations completed.</p> <p>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. Section 31 notifications have been made in relation to this. The service has been recruiting registered nurses through the competency assessment programme (CAP) and now have a full complement of registered staff.</p> <p>The service has a comprehensive role-specific orientation programme that provides new staff with relevant information for safe work practice, however not all members of staff have documented orientation on file. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service.</p> <p>A completed in-service calendar for 2018 and 2019 exceeded eight hours annually, however not all of the compulsory training sessions have occurred over the two-year period. The management team and registered nurses attend external training including seminars and education sessions with the local DHB. Twelve of the 18 registered nurses have completed their interRAI training.</p> <p>There are ten healthcare assistants (HCA) who work in the dementia unit. Seven of these ten HCAs have completed the required NZQA dementia standards. One HCA has recently commenced employment and is aware of the requirement to complete the required training, one is due to start the training and one is currently completing the training.</p> |

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| | | <p>There are 17 HCAs who work in the psychogeriatric unit. Twelve of the 17 staff members have completed the required dementia standards, including three HCAs with level 4 NZQA, the activities assistant has completed level 4 NZQA. Of the staff who have not yet completed – one is new staff, three are completing, and one HCA is awaiting marking.</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 acting facility manager works Monday to Friday. The clinical manager works Monday to Friday and is available for advice to the on-call RNs and unit managers.</p> <p>The Redwood (hospital) 30 residents: The unit manager works Monday to Friday 7 am to 3.30 pm. An RN is rostered on all shifts; they are supported by five HCAs rostered on the morning shift. There are two shifts; 7 am to 3.30 pm and 7 am to 1 pm. The allocation is based on the contracted hours of HCAs, there is a minimum of two HCAs on the long shift. There are days on the roster where all five HCAs are rostered on long shifts.</p> <p>There are five HCAs rostered on the afternoon shifts from 12.30 pm to 9 pm and 4 pm to 9 pm, again the coverage is based on contracted hours. One HCA and the RN are rostered overnight from 8.45 pm to 7.15 am.</p> <p>Taieri (psychogeriatric) 21 residents: The unit manager works three days a week and covers RN shifts for two days. A registered nurse is rostered across all shifts, an enrolled nurse is employed who covers HCA shifts as required. They are supported by four HCAs who work between 7 am to 3.30 pm and 7 am to 1 pm depending on contracted hours. The afternoon shift has four HCAs rostered over 12.30 pm to 9 pm and 4 pm to 9 pm. HCA and RN cover night shifts.</p> <p>Ferntree (dementia) 15 residents: The unit manager/RN works four days a week 7 am to 3.30 pm. Medicine competent HCAs are rostered afternoon and night shifts with oversight provided by the RN in Taieri in the first instance with Redwood staff if required. They are supported by two HCAs on the morning shift from 7 am to 3.30 pm, two HCAs in the afternoon from 12.30 pm to 9 pm and one HCA overnight from 8.45 pm to 7.15 am.</p> <p>Staff interviewed felt overall there was sufficient staff on duty. Casual and agency staff which have been utilised when required. Staff interviewed from the dementia units stated agency staff were seldomly utilised.</p> |
| <p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with</p> | PA Low | <p>There are comprehensive policies and procedures in place for all aspects of medication management. There are three medication rooms on site, one for each level of care and all have secured keypad access. Medication fridges (two) have daily temperature checks recorded and were within normal ranges. Controlled drugs are checked weekly. Registered nurses, enrolled nurses and senior healthcare assistants who have passed their medication competency administer medications. Medication competencies are updated annually and include syringe driver competency. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Medication administration practice complies with the medication management policy as observed during the mid-day medication round. There is a signed agreement with the pharmacy. Medications are checked on arrival and any pharmacy</p> |

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| <p>current legislative requirements and safe practice guidelines.</p> | | <p>errors are recorded and fed back to the supplying pharmacy. The service does not use standing orders. There was no resident self-medicating at time of audit.</p> <p>The facility utilises an electronic medication management system. Twelve medication profiles were sampled (four hospital, four dementia rest home level of care and four psychogeriatric). All charts had photo identification and allergy status documented. All medication charts evidenced three monthly reviews by the GP. Prescribed medication is signed electronically after being administered as witnessed on the day of the audit. Effectiveness of 'as required' medication administered was documented in the electronic prescription.</p> <p>An improvement is required relating to monitoring of medication room temperatures.</p> |
| <p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p> | <p>FA</p> | <p>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. The contractor has a Food Control plan expiring December 2020. The external contractor conducts audits as part of their food safety programme. Fridge and freezer temperatures are monitored and recorded daily in the kitchen. Food in the fridge and freezers was covered and dated. Special or modified diets are catered for. Soft and pureed dietary needs are documented in files sampled. This includes consideration of any particular dietary needs (including cultural needs).</p> <p>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 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p> | <p>FA</p> | <p>All care plans of the resident files reviewed were resident focused and individualised. Long-term care plans identify support needs, goals and interventions to manage medical needs/risks. Care plans include allied health and external service provider involvement.</p> <p>Short-term care plans are completed for infections, wounds, nose bleeds, and weight loss. Interventions are added to the long-term care plan when health status indicates an unresolved issue and removed when resolved. The care plans reviewed evidenced they were updated and reviewed when changes to health status occurs.</p> <p>Allied health care professionals involved in the care of the resident included, but were not limited to physiotherapist, wound care specialist nurse, district nurses, dietitian, and community mental health services. The previous finding relating to documentation of interventions has been closed.</p> |

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| <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>The registered nurses conduct a nursing review six monthly and as resident health status changes, including referral to GP, nurse specialists and dietitian. There is documented evidence on the family/whānau contact form in each resident file that evidences family were notified of any changes to their relative's health including (but not limited to) accident/incidents, behaviours, infections, health professional visits, referrals and changes in medications. Residents interviewed reported their needs were being met. Discussions with families confirmed they are notified promptly of any changes to their relative's health.</p> <p>Wound management policies and procedures are in place. The service is currently managing fourteen wounds including two stage two pressure related injuries. The pressure related wounds have a care plan written, including skin and pressure prevention measures, however there was insufficient documentation of wound assessment and management for one pressure injury. There is external specialist input into residents.</p> <p>Contenance products are available and resident files include a urinary continence assessment.</p> <p>Dressing supplies are available and all treatment rooms are stocked for use.</p> <p>Monitoring forms are available for vital signs, challenging behaviour, wounds, restraint and continence, however monitoring forms for repositioning and toileting schedules were not always completed (also link 2.1.1.4).</p> |
| <p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p> | <p>FA</p> | <p>The activity programme is developed by an occupational therapist together with three qualified diversional therapists (DT). The activity team provide a separate activity plan for each area (hospital, dementia, psychogeriatric) and cover seven days per week in the psychogeriatric unit, five days in the hospital and dementia units. The activity programme is planned monthly. Activities planned for the day are displayed on noticeboards around the facility. An activity plan is developed for each individual resident based on assessed needs of the functional activity assessment completed on admission. 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. The service has a van that is used for resident outings. Resident meetings provide a forum for feedback relating to activities. Residents and family members interviewed discussed enjoyment in the programme and the diversity offered to all residents.</p> <p>A social history is completed on admission and information gathered is included in the care plan. The activity care plan is developed with the relative (and resident as able) and this is reviewed at least six-monthly.</p> <p>Healthcare assistants in the dementia and psychogeriatric units were observed during the day diverting residents from behaviours. The programme observed is appropriate for people with dementia related conditions.</p> |

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| <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>Care plans reviewed had been evaluated at least six-monthly and were updated as changes were noted in care requirements in files sampled. The care plan evaluations are resident focused and describe residents progress to meeting identified goals. When health status changes acutely, short-term care plans were utilised and any changes to the long-term care plans had been dated and signed in files sampled.</p> <p>All initial care plans are evaluated by the RN within three weeks of admission.</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>PA Moderate</p> | <p>The building warrant of fitness expired on 16 March 2019. The service has an extension (from the monitoring company) to have outstanding building issues relating to fire wall damage during reconstruction until May 2020, rectified. Electrical equipment has not been tested and tagged in 2019. Medical equipment has not been calibrated by an authorised technician during 2019. Reactive and preventative maintenance occurs. There is a planned maintenance programme in place. Hot water temperature has been monitored monthly (with the exception of the month of December 2019) in resident areas and were within the acceptable range.</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 monitoring is the responsibility of the infection control coordinator (clinical manager). All infections are entered into the electronic database, which generates a monthly analysis of the data. The data is discussed at the management/quality meeting; however, this is not always discussed at the unit meetings (link1.2.3.6). The data is summarised three monthly; graphs and narrative of the data (sighted) was available for staff to review on staff noticeboards.</p> <p>Since the previous audit the infection control coordinator has been working to build strong relationships with the Public Health service and stated there is more detailed data collected with the electronic system. A register of multi-resistant organisms (MROs) are maintained for staff and residents who have reported cases.</p> <p>There was a suspected gastroenteritis outbreak December 2019 and the service implemented outbreak management precautions. The case logs were maintained, notifications were made appropriately, and staff were well informed. The outbreak was contained in the dementia and psychogeriatric units. The outbreak was well managed and staff interviewed could fluently describe the swift actions taken and measures to prevent the outbreak spreading to the hospital unit. There was documentation of a post outbreak debrief.</p> |
| <p>Standard 2.1.1: Restraint</p> | <p>PA Low</p> | <p>The service is committed to restraint minimisation and safe practice which was evidenced in the restraint policy and interviews with RNs and healthcare assistants. Policies include managing patients' challenging behaviours,</p> |

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| <p>minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p> | | <p>alternatives to restraint and guidance for staff in responding to challenging behaviours and patients' needs. The service endeavours to provide a restraint-free environment. Restraint minimisation is overseen by a restraint coordinator who is a unit manager. A full assessment is completed prior to restraint usage.</p> <p>The resident file sample was extended by one to review the enabler processes. There was one hospital resident documented as using an enabler. During review of the file (only the enabler section of the care plan), it was identified that the resident was unable to indicate voluntarily the use of the enabler, therefore, was identified as restraint on the day of the audit. Consent has been completed by the GP; however, this has not been updated since 2013, and monitoring has not been completed for all periods of usage as per the policy.</p> |
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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) |
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| <p>Criterion 1.1.13.1</p> <p>The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.</p> | PA Low | Complaint forms are available for residents and relatives to access. Relatives and residents interviewed were aware of how to make a complaint and the complaint process. | Two of two complaints received in 2019 had no supporting documentation of response in a timely manner. | <p>Ensure all complaints received are acknowledged and followed up within timeframes.</p> <p>90 days</p> |
| <p>Criterion 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p> | PA Low | Complaints register was in place for 2018 detailing the complainant, dates of acknowledgement, issue and actions taken, including dates of discussions, meetings and outcomes. All complaints had been closed off. There is a proposed register in place for | There was no documented complaints register for 2019. | Ensure the complaints register is maintained for 2020. |

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| | | 2020, however there was no evidence of a complaints register for 2019. | | 90 days |
| <p>Criterion 1.1.9.1</p> <p>Consumers have a right to full and frank information and open disclosure from service providers.</p> | PA Low | Residents and relatives interviewed overall felt there was a good flow of communication. The relatives interviewed felt they were well informed of changes in resident condition and following incidents. However, not all incidents were reported to family. | Notification to relatives of two dementia residents and one psychogeriatric resident were not documented, and the reason for not notifying relatives was not evident in the electronic adverse event form or the progress notes. | <p>Ensure the notification (or reason why not) is documented following adverse events.</p> <p>90 days</p> |
| <p>Criterion 1.2.3.1</p> <p>The organisation has a quality and risk management system which is understood and implemented by service providers.</p> | PA Low | The last strategic plan and quality plan available expired at the end of 2018. The acting facility manager and the clinical manager described the quality initiatives they have implemented and achieved throughout the last year, and the staff interviewed could describe the changes made in the last year. Due to the changes in management this has not been documented or reviewed formally. | <p>(i) There was no documented quality plan for 2019.</p> <p>ii) There is no documented strategic plan in place since 2018.</p> | <p>(i)-(ii). Ensure there are strategic, quality and risk management plans in place to evidence quality improvement and direction.</p> <p>180 days</p> |
| <p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to</p> | PA Moderate | Monthly internal audits are performed for each unit around medication management and hot water temperatures, however there | (i) There have been no clinical, HR or | (i) Ensure internal audits are completed |

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| <p>service providers and, where appropriate, consumers.</p> | | <p>have been no other internal audits completed. Corrective action plans have been developed and signed off when completed. Meetings have been held according to schedule, however not all information is consistently discussed. A resident survey was held in 2018, the results were collated and discussed with staff, however no survey had been completed in 2019.</p> | <p>environmental audits completed for 2019.</p> <p>(ii) Quality data of falls and infection rates are not consistently discussed at unit meetings. Staff were unable to describe this during interview.</p> <p>(iii) There has been no resident survey completed in 2019.</p> | <p>according to the schedule.</p> <p>(ii) Ensure discussions held in meetings around quality data are captured in the meeting minutes.</p> <p>(iii) Ensure a resident survey is performed in 2020 in line with the ARC agreement.</p> <p>90 days</p> |
| <p>Criterion 1.2.3.9</p> <p>Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:</p> <p>(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;</p> <p>(b) A process that addresses/treats the risks associated with service provision is developed and implemented.</p> | <p>PA Low</p> | <p>Health and safety meetings occur monthly. The facility has recently appointed a health and safety contractor. New hazards and ongoing corrective actions are discussed and documented in the minutes of the meetings; however, the hazard register has not been formally reviewed in the last year.</p> | <p>The hazard register has not been reviewed since 2018.</p> | <p>Ensure the hazard register is reviewed at least annually.</p> <p>90 days</p> |

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| <p>Criterion 1.2.7.4</p> <p>New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p> | <p>PA Low</p> | <p>Orientation is available to new staff employed at Leslie Groves. General orientation includes aspects of health and safety including hazard identification and management, emergency procedures, incident reporting, resident rights, infection control competency, hoist competency and equipment safety. Role specific orientations were sighted for registered nurses, HCAs, and housekeeping staff; however, role specific orientations were not in place for all staff.</p> | <p>i) No role-specific orientation documented for two of six staff files including the clinical manager, a unit manager and the occupational therapist.</p> <p>ii) Three of six staff files reviewed did not have a current appraisal.</p> | <p>Ensure all staff complete orientation documentation, and staff appraisals are completed according to policy.</p> <p>180 days</p> |
| <p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p> | <p>PA Moderate</p> | <p>Education sessions have been occurring at Leslie Groves. A focus has been on palliative care and Te Ara Whakapiri implementation. Sessions have been held on restraint minimisation and challenging behaviours, outbreak management, manual handling, first aid and medicine competencies were all current, however not all compulsory education sessions have been held over the last two years.</p> | <p>No evidence of education sessions in 2018 or 2019 around advocacy, falls minimisation, continence, pressure injury prevention, health and safety, chemical safety, the aging process and sexuality and intimacy.</p> | <p>Ensure outstanding education sessions are included in the 2020 education planner.</p> <p>90 days</p> |
| <p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with</p> | <p>PA Low</p> | <p>Aspects of medicine management such as prescribing, dispensing, administration, GP reviews, returning of medication to the pharmacy, and medicine reconciliation are completed as per policy. Monitoring of medication fridge temperatures have been</p> | <p>Temperatures of the medication rooms were not monitored or recorded.</p> | <p>The temperature of the medication rooms are monitored daily at the warmest</p> |

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| legislation, protocols, and guidelines. | | recorded daily and were within the acceptable range, however the temperature of the medication rooms had not been monitored. | | time of the day. 90 days |
| <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> | PA Low | Monitoring forms are available for vital signs, challenging behaviour, wounds, restraint and continence. | Monitoring forms for repositioning, toileting schedules and checks were not always completed. | <p>Ensure monitoring forms are maintained as per care plan intervention.</p> <p>90 days</p> |
| <p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p> | PA Moderate | The building warrant of fitness expired on 16 March 2019. The service has an extension (from the monitoring company) to have outstanding building issues relating to fire wall damage during reconstruction until May 2020, rectified. Hot water temperatures are monitored monthly (with the exception of December 2019) and any discrepancies are referred to a plumber for attention. | <p>(i) Hot water temperatures have not been monitored for the month of December 2019.</p> <p>(ii) Medical equipment has not been assessed or calibrated annually.</p> <p>(iii) There was no current building warrant of fitness in place.</p> | <p>(i) Ensure hot water temperatures and equipment is monitored or calibrated as per legislation.</p> <p>(ii) Ensure all medical equipment is assessed and calibrated annually.</p> <p>(iii) Ensure a current building warrant of fitness for the hospital is obtained.</p> |

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| | | | | 60 days |
| <p>Criterion 2.1.1.4</p> <p>The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.</p> | PA Low | <p>Restraint minimisation is overseen by a restraint coordinator who is a unit manager. There is one hospital resident documented as using an enabler (found to be restraint on the day of the audit). Consent has been completed by the GP, not updated since 2013. A full assessment is completed prior to restraint usage.</p> | <p>i) Monitoring forms have not been completed for all periods of usage.</p> <p>ii) Consent has not been reviewed as per the policy.</p> | <p>i) Resident using restraint is reassessed and approval is completed as per policy for restraint.</p> <p>ii) Resident is reviewed as to the need of restraint due to changes in health status.</p> <p>90 days</p> |

Specific results for criterion where a continuous improvement has been recorded

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

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

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

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End of the report.